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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, ana Aaministration of Hospitals, Sanatoriums, and Allied Institutions, and to their Medical, Surgical, and Nursing Services

Vol. III *December, 1914* No. 6

THE RELATIONSHIP OF POVERTY AND SICKNESS AND OF BOTH TO THE HOSPITAL.

Money Is Wasted That Cures a Man Only to Let Poverty Induce Illness Again—A Large Percentage of Sickness Among the Poor Traceable to Their Poverty—Duty of the Hospital to Point Out the Real Cause of Sickness, So That Society May Remove It.

By STEWART M. JOHNSON,

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IT is not the object of this paper to discuss which of the two, poverty or sickness, is the cause of the other. There is no difficulty in finding evidence in abundance to prove either that much poverty is caused by sickness, or the other way about, that much sickness is caused by poverty. It is generally agreed that the two causes interact mutually, and compose a vicious circle. But if it is a matter of debate which of the two comes first in the cycle, there can be little doubt which comes last, and that is sickness. The series may be written—

Poverty: Sickness,
or
Sickness: Poverty, Sickness.

In each case the terminal is the same. Death, or, in other words, sickness successful, is rarely due to poverty uncomplicated by sickness. Deaths from starvation, from poverty pure and simple, are all but unknown in civilized countries.

The experience of "fasting men" has shown that, with suitable precautions, the human body can lose almost half its weight without fatal result or great discomfort. In the rough and tumble of the world, however, long before so large a proportion of wasting has taken place, the subject, enfeebled by privation, falls a prey to disease. The first attack may be repulsed, but the assaults are repeated until the patient succumbs. It is well known that the death rate among the poor is higher than among the rich, and that a high death rate is accompanied by a high rate of sickness which does not immediately end in death.

Now, the spectacle of sickness combined with poverty customarily excites the commiseration of the well-to-do. Poverty unattended by sickness, be it remarked, has frequently the reverse of this effect. Witness the barbaric penalties enacted against the "sturdy vagrants" of the Elizabethan age, and the harsh treatment of able-bodied paupers in comparatively recent times. But sickness and poverty together touch the heart of the comfortably-off. That selfishness transcending self which urges man to treat his neighbor as himself impels the better-off to provide for the less fortunate all the machinery for the treatment of sickness—doctors, hospitals, dispensaries. This machinery, whether charitable in the sense that it is the product of voluntary effort, or only so in the secondary sense that its support by taxation is unresisted, is constructed in the spirit of charity—the spirit, namely, that bids man do unto others as he would they should do unto him. When the rich man is sick, he sends for a doctor, takes to his bed, or perhaps goes into a nursing home. When the poor man is ill, the rich man supplies him accordingly with a doctor and a hospital ward or out-patient department.

But, whereas the rich man leaves the consulting room or the nursing home free to follow the advice given him, and with a reasonable prospect of remaining in the health he has been enabled to

regain, the poor man is discharged cured, or relieved, it may be, in the majority of cases, of his particular complaint for the time being; but so far as concerns his poverty, the primary or secondary cause of his illness is in the same state as when he came in. His poverty, unrelieved, is bound to bring sickness in its train again, and again and again until at last death, the consummation of sickness, is achieved. When this event happens, all the money spent on his medical treatment is lost—not merely, be it remarked, the expenditure on his final fatal illness, but all as well that has been expended, with temporary success, on his previous illnesses. For example, a poor man may be relieved of appendicitis by the removal of his appendix; he may be operated on for rupture and be enabled to resume a life of toil; vaccination may preserve him from smallpox, antitoxin may rescue him from diphtheria; he may be successfully nursed through pneumonia or an attack of acute rheumatism, only to die a year or two later of consumption. Then not only is the money laid out on the treatment of his phthisis wasted, but also all that has previously been paid for attendance on his earlier maladies. It is manifest, therefore, that the treatment of sickness in the poor requires something in addition to the medical attendance which the rich man, anxious to do unto others as he would they should do unto him, provides on his primal impulse. Hospital authorities have in recent years awakened to this truth, and almoners and social service departments have been instituted to cooperate with other agencies for the prevention or alleviation of poverty, so that the medical treatment shall not be handicapped by social disabilities other than sickness.

The usefulness of the social service department to the hospital is beyond doubt. There can be no question that it does much to break the vicious circle by which sickness and poverty each drag the other in train. It provides convalescence or instruments for the discharged patient; it looks after the children while the mother is in hospital; it supports the family of the early consumptive while he is in a sanatorium; it procures work for the unemployed, it restores self-respect to the downtrodden and prudence to the thriftless; in short, it mitigates the evils incident to sickness and poverty in countless different ways. The social service department has at last, after a struggle against blindness and indifference, won for itself so secure a position in the estimation of hospital authorities that the danger now is lest it should be supposed that the problem of the interaction of sickness and poverty on one another has been solved and that there is nothing further to be done. The fact has been allowed to slip out of sight that, unless the efforts of the social service department are sufficient to place the patient permanently above the poverty line, the money it expends on him is just as much lost in the long run as the cost of the medical treatment. So long as the breadwinner is not enabled to earn a wage sufficient to supply himself and his dependents with adequate diet, house room, warmth, and clothing, then the money spent on convalescence, on the hire of the deputy mother, on the maintenance of the consumptive's household, in finding employment for the workless, even the time occupied in encouraging the downhearted or reproving the improvident, is thrown after the money laid out on the removal of the appendix, the radical cure of hernia, the injection of vaccines or sera, the skilled nursing for persons whose lives are fated to be lost prematurely by illness induced by poverty. Were the numbers that answer to this description attending hospitals insignificant, nothing further need be said, but there is reason to believe that in London, at any rate, patients of this class form a not small minority. It was estimated by Mr. Charles Booth that during the period 1890 to 1900, in London, one-tenth of the population was in extreme poverty, "in chronic want," and that another two-tenths were in poverty, "living under a struggle to obtain the necessaries of life."

Similarly Mr. Rountree in 1900 found that one-tenth of the population of York was in primary poverty—that is, "their total earnings were insufficient to obtain the minimum necessaries of merely physical efficiency"; and that approximately two-tenths more were in secondary poverty—that is to say, "their total earnings would be sufficient for the maintenance of merely physical efficiency, were it not that some portion of it is absorbed by other expenditure, either useful or wasteful."

From the evidence given before the recent royal commission on the Poor Law and before the King's Hospital Fund Committee of Enquiry it appears probable that two-fifths of the outpatients attending the London hospitals are drawn from that one-tenth of the people who are in extreme or primary poverty, while the remaining three-fifths, with the exception of a not great proportion of better-off "consultation" cases, are in secondary poverty or poverty that is not extreme. It is among this latter class that the social service department can achieve its best results. For those "living under a struggle to obtain the necessaries of life" it can give assistance just in the nick of time; it can intervene on the side of the struggler at a critical moment; it can tide his family over a temporary crisis. It

can advance the loan or provide just the little extra for those "whose earnings would be sufficient, were it not that a portion is absorbed by some useful expenditure," or give help, conditional on reform and self-effort, to those whose earnings are rendered insufficient by wasteful spending. It can prevent by timely aid the poor man falling from poverty to extreme poverty; it can even in some cases raise him out of poverty altogether.

But in the case of those two-fifths of the patients who belong to the primary poor, who live in chronic want, unless the help given is sufficient to eject them out of that class altogether, to shoot them up into the class above, where life is at least a struggle and not a defeat, the time and money spent alike by the medical and the social service department is predoomed to loss. The patient is cured of one disease only to be stricken with another—only helped out of one financial crisis to fall into the second. Thrift is impossible, since he can provide for the future only by depriving himself of present necessities; he is incapable of self-effort, since all effort, mental as well as physical, is the product of the consumption within the body of food of which he has not a sufficiency. The more that is spent on such a patient, the more is ultimately lost, and he goes down into his grave carrying with him the odd hundred pounds or more that have been vainly sunk in him in the endeavors to keep him alive.

Although it is possible that the proportion of the population, and consequently of hospital patients, in poverty is greater in London than elsewhere, it is nevertheless certain that the number of sick too poor to profit by medical and social assistance in every great capital city of the world must be not inconsiderable.

What are the hospitals to do in these circumstances? How are they to deal with this class of patients? Some people might say that they should be referred to the Poor Law authorities. This is a mistake. Although poor, these persons are not paupers; although "in want," they are not, to use Mr. Booth's contrasted terms, "in distress." Moreover, the Poor Law authorities would be in just such a fix as the voluntary hospitals. What the majority of them require is 25 percent increase in wages or in work, and to provide this the Poor Law is just as powerless as private charity. Subsidies in aid of wages only aggravate the evil they attempt to cure.

Poverty due to low wages and irregular work can be abolished only by combined action. The causes in the first instance are social, not individual, and can be attacked only by social measures. Whether it is inevitable that some fraction of the people must always be unable to earn sufficient to satisfy the barest needs of existence; whether the ideal of the French king, that every man in the land should have a chicken in the pot on Sunday, can never be realized; whether the argument that a degree of poverty is necessary for the welfare of the nation to secure the elimination of the unfit in each generation—such questions need not detain us on this occasion. It is enough that, so far as the causes of poverty and sickness due to poverty are social, the hospital can do nothing directly to counteract them. But if the hospital cannot act, it can give evidence, it can furnish data, it can state the facts in order that others may solve the problem. Not that this task is so easy as it seems; in the very nature of things a hospital supported by voluntary offerings must talk about what it does and not about what it cannot do. In making appeals, its principal mode of addressing the public, it is compelled to lay stress on what it accomplishes. To call attention to what it leaves undone is not a good way to obtain money.

Yet it is the interest of the hospital, more than of any other charity or agency for the assistance of the poor, to make the truth known, for, while other bodies relieve only that fraction of the population whose poverty is due to causes which they set themselves to alleviate, the hospitals deal ultimately with all poor people, since, as we have seen, poverty and sickness lead always finally to sickness and further sickness and death. All hospitals should combine together for the purpose, and should lose no opportunity of impressing on the public that, while money can scarcely be put to better advantage than the treatment of such illness as is unavoidable, or to be avoided only by an attention to health, which is more inconvenient than ill-health, yet money that has to be spent on treating illness that is merely the terminal phase of poverty is diverted from its proper use. Medical treatment should be directed against such illness as is an intrusion into the normal life of the sufferer, and not against such illness as is the outcome of the patient's ordinary mode of life. Though hospitals, out of humanity, must continue their ministrations to the very poor, yet, until poverty is abolished or diminished by other means chiefly social and economic, much of the money spent by them is lost.

In mentioning Dr. Guy Manson, superintendent of the fine 150-bed county hospital at Fresno, Cal., one of the Fresno newspapers attributes his excellent qualities, in part, to what it describes as "about two pounds of near-red hair." In addition, however, Dr. Manson is credited with one hundred and ninety-eight pounds of discretion, efficiency, good nature, and professional ability, the last-named qualification being directed particularly along surgical lines.

NEW YORK HOSPITAL FOR RUPTURED AND CRIPPLED.

New Edifice Built by the New York Society for the Relief of Ruptured and Crippled Contains Every Device for This Class of Patients—Best Substitute for Country Life Attempted—School and Kindergarten Under Board of Education.

BY OUR NEW YORK CORRESPONDENT.

IT is only of late years that society has awakened to the relief of handicapped cripples and to the possibility of making an increasing number independent and useful members of the community. In the dim past the Orientals turned their cripples into the wilderness, ancient India cast them into the Ganges, the Spartans hurled them from precipices, and the Jews banished them to beg by the wayside. For centuries their principal calling was jester or beggar, but, with the comparatively recent advance in orthopedics and the wave of general uplift, they are now either restored to health or at least fitted with apparatus that makes available the vocational training offered in special hospitals and schools.

It is impossible to estimate with any degree of accuracy the number of cripples in the United States. The Department of Child Help of the Russell Sage Foundation has just finished a two-year exhaustive survey of thirty-seven of our institutions for crippled. Of these, ten were hospitals, fourteen convalescent homes, and thirteen asylum homes. The survey was undertaken to procure detailed information regarding present conditions as a basis for work toward standardization. Dr. Hart has the report now in press. It bids fair to make not only an extremely interesting volume, but will doubtless go far toward the discovery of the most efficient methods of bringing hope and cheer to approximately 250,000 cripples in the United States.

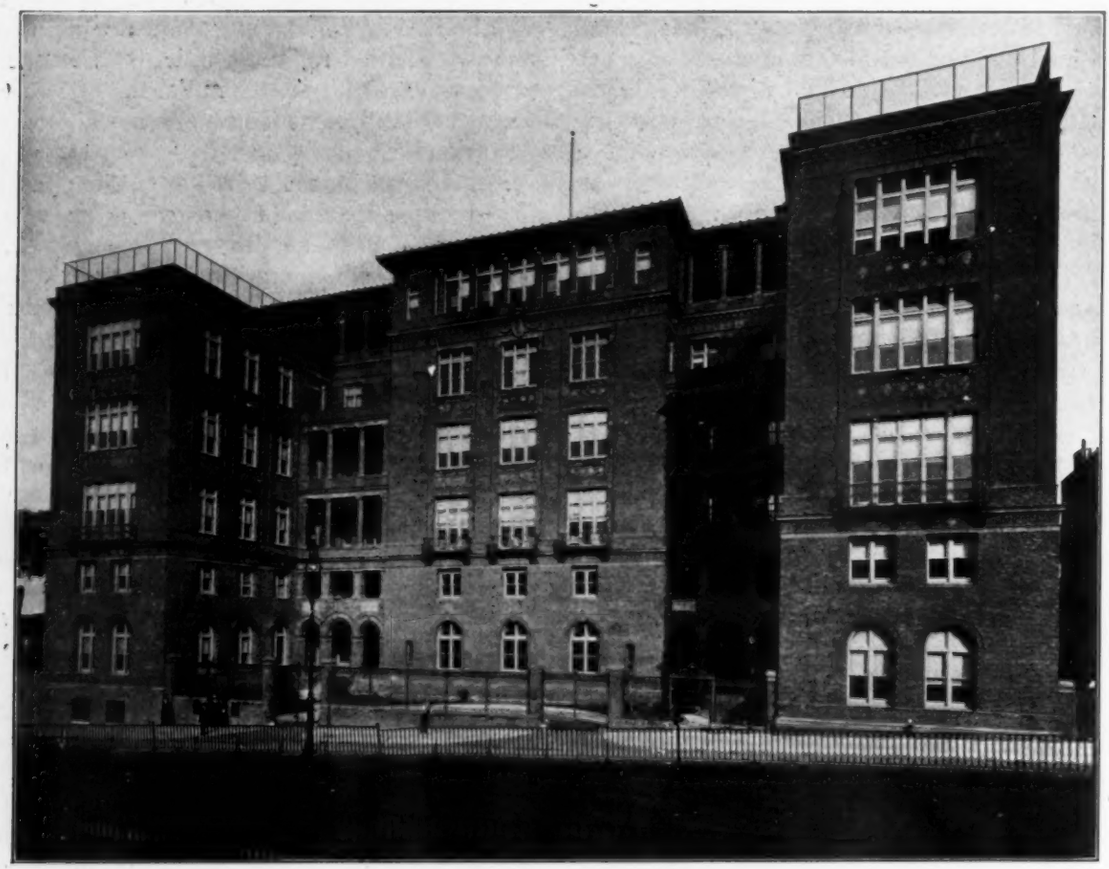

Fig. 1. Hospital for Ruptured and Crippled—Front view.

Among the first to come to the aid of this class of "physical defectives" in America was the New York Society for the Relief of the Ruptured and Crippled. This society came into being in 1862 through the efforts of the late Dr. James Knight. The high standards of professional skill and traditions of tenderness toward these unfortunate pa-

tients, insisted on by Dr. Knight as surgeon-in-chief of the original hospital built in 1872, are upheld today by Dr. Virgil P. Gibney, surgeon-in-chief of this splendid new hospital, opened in 1913. Dr. Gibney served under Dr. Knight for many years, and with six members of the present board of trustees, sons or grandsons of the early boards, enjoys the closest cooperation in his successful endeavors toward careful and efficient management.

In the construction of this new hospital care was taken to have large courts for plenty of light in the upper stories, and wide areas for sufficient light and ventilation in the basement. It is the most modern type of fireproof construction, designed in the Renaissance style of northern Italy. The wall surfaces and the shafts of the octagonal columns are constructed of a buff wire-cut brick, laid in Flemish bond. Secondary cornices, band courses, capitals, etc., of ornamental terra-cotta tone in with the brickwork, the main cornice being of copper. This special hospital, with an out-of-door annex to every ward and sufficient roof space to conduct the ward work and school work in the open, with a minimum amount of transportation, represents the best possible city substitute for life in the country.

The excellent floor plans visualize, far better than any detailed description, the admirable results obtained by the architects, Messrs. York & Sawyer, and the building committee.

All supplies are delivered through the northwest court at a covered platform the height of a wagon-bed. They are lowered on an electric lift to the service yard on the basement level. A glass roof covers part of this yard, and the crated goods are here unpacked. From this yard opens a vault for coal used in the kitchen and the forges of the brace shop, and also a small autopsy room, lighted above, containing two mortuary receptacles.

Fig. 2. Hospital for Ruptured and Crippled—School and kindergarten.

There is a complete plant for heating, ventilating, lighting, power, and refrigeration in the basement and subbasement. The kitchen is equipped with strictly modern cooking apparatus, and the floor and walls are of white tile. Two automatic dumbwaiters, serving the main pantries, open directly into the kitchen. The laundry contains, in addition to the modern individual motor-driven apparatus, two large sterilizers, a Kenyon-Francis for dry sterilization and another

for moist. Both are built into the laundry wall and fed from a room opening on the main corridor near the freight elevator. The brace shop, with its auxiliary rooms for sewing, leather work, etc., connects directly with the dispensary, on the floor above, by a separate staircase and dumbwaiter. All the machines are of the latest design, and overheated shafting is avoided by direct-connected motors. Here all braces, trusses, etc., for both in- and out-patients are manufactured and kept in repair.

Dispensary and in-patients are admitted at the westerly entrance into a beautiful, large waiting room two stories in height. High windows on the north and south give an abundance of light and natural cross ventilation. A cross-vaulted ceiling, painted decorations, and a quarry tile floor, with a marble border and base, render this room extremely attractive. In the rear is an inclosed space for the registrar, admitting clerk, and cashier. On the right of this inclosure is the door entering the hernia department and on the left the orthopedic, thus giving the registrar control of the dispensary patients. The three rooms of the hernia department have built-in cabinets for trusses, etc., and each is fitted with curtains hung from the ceiling, which, when drawn, divide them into alcoves. The large room in the orthopedic department for the examination of children contains twelve booths, separated by low partitions of Knoxville marble. All the floors of the dispensary are of tile, with a tile sanitary base. The wisdom of planning the brace shop with its finishing rooms, the x-ray department, the gymnasium and Zander room, the quarters for electrotherapy, vibrassage, hydrotherapy, and baking, to be of practical service as accessories to the out-patient department, has been fully demonstrated by the efficiency of this dispensary. Last year 11,928 patients were recorded for treatment in the orthopedic department, and 4,399 on the hernia side. The gymnasium was well patronized by children in need of muscular development, and hundreds of early cases of lateral curvature were successfully corrected. Massage operators are supplied for out-patients as well as those in the hospital wards, and, by cooperation of the College of Dental and Oral Surgery, the teeth of all patients receive proper care. A social service department has recently been organized to cooperate with the dispensary.

Fig. 3. Hospital for Ruptured and Crippled—Children in the solariums.

The two main staircases, located in the east and

west wings of the main building, are entirely inclosed and separated from the main corridors by fireproof doors. Emergency stair-cases in the north wings are also inclosed, and have exits at the second floor to the roof over the court, from which two fire-escapes lead to the street. Inclosed passenger elevators, large enough to receive stretchers, serve the two sides, and a freight elevator near the service entrance runs from the subbasement to the sixth floor.

The second floor, a low story, is entirely given up to living quarters for the superintendent, staff, matron, housekeeper, graduate nurses, and female help. In the plan of this floor one notes that the superintendent's suite is so placed as to control the staff rooms, while the matron's has control of the graduate nurses and female help.

The four ward units of the third floor are severally separated from the main corridor by double doors. The flooring of the wards is of an imported buff tile; of the corridors and dining rooms, terrazzo, divided with marble borders; and of the quiet rooms and toilets, white tile. Every dressing room has a bracket for the harness used in adjusting plaster jackets, a sink, and water and instrument sterilizers. The toilet and bath rooms are spacious, to render easy entrance and egress to patients in wheel-chairs. Each contains, besides the usual fixtures, a marble bathing slab, with sink attached, for patients that cannot be bathed in the tub. The three south wards open directly on the two loggias, while the flat roof over the low northwest wing is accessible from the main corridor.

The plan of the fourth floor duplicates the third, save that the operating suite takes the place of the ward unit in the northeast wing. The main operating room is naturally lighted by a north window skylight constructed of steel and wire glass. Its amphitheater has fifty seats for students and visiting physicians, and is entered by a staircase from the floor above. The small pus operating room has a gallery with fourteen seats, and is also accessible from the floor above. These seats in the amphitheater and gallery are supported on brackets, and made of enameled iron modeled somewhat like a bicycle saddle. They are not only sanitary, but allow a maximum space for passageway. The operating suite is fitted with thoroughly modern equipment, and the floors and walls of the operating, sterilizing, and instrument rooms are of white tile. There were 683 opera-

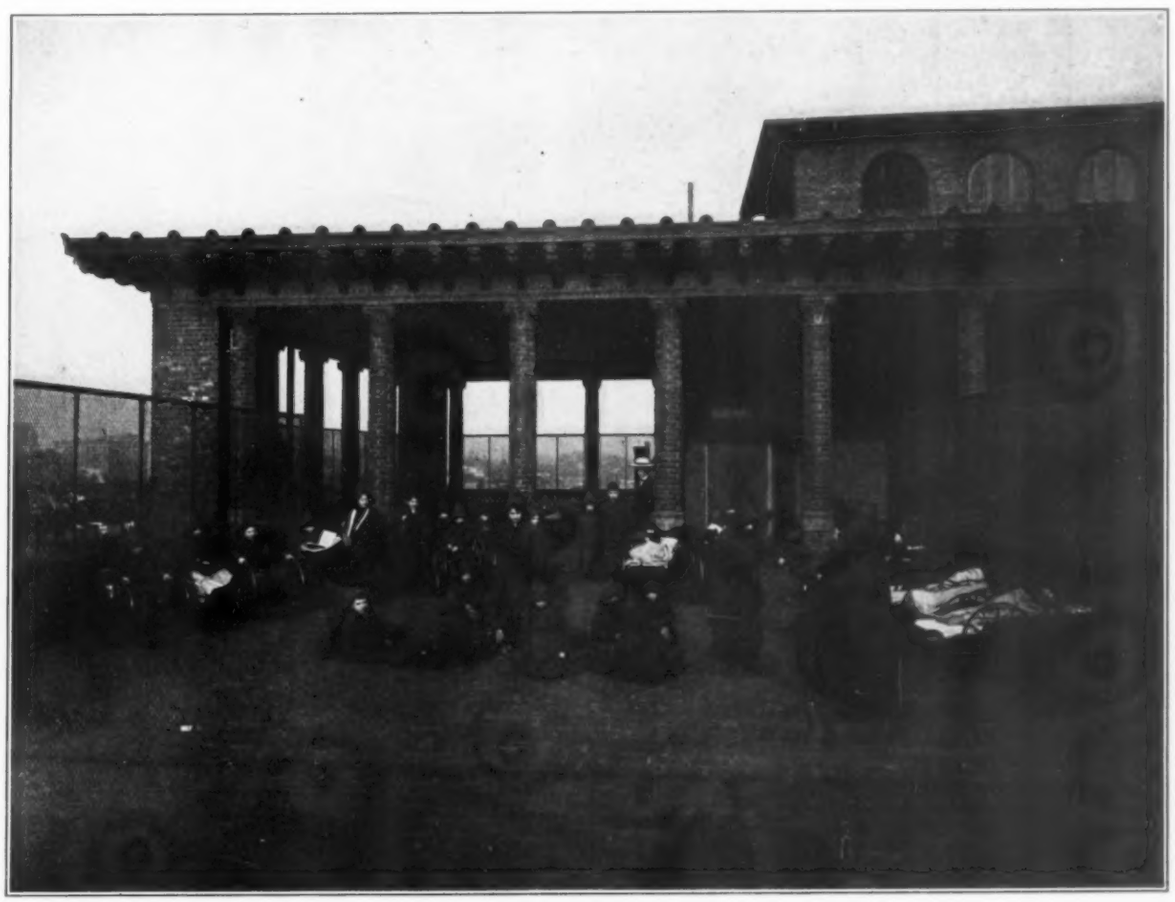

Fig. 4. Hospital for Ruptured and Crippled—Roof gardens are the best substitute for the country.

tions for the correction of deformities and 478 for hernias performed during last year in this institution.

The school and kindergarten, under the supervision of the board of education, are conducted on the fifth floor. All the children able to attend school assemble for morning exercises in the large central room. This assembly room, with its cross-vaulted ceiling and quaint decoration of a nature to interest the little ones, is also used by the kindergarten, for serving the midday meal to all the school children, for a play room in the afternoon, and for special entertainments.

The sixth floor, planned with a flat roof for outdoor treatment, is divided by the solarium into two sections, one utilized by the boys and the other by the girls. A large part of each section is roofed over, so that patients may remain in the open even in stormy weather. The attractive view in all directions is unobstructed, and danger avoided by a wire mesh screen built above the low masonry parapet. Meals may be served on the roof from pantries on this floor. The solarium, with its dependencies, is so planned and equipped that it can be utilized as an isolation ward in the event of a contagious outbreak in the hospital.

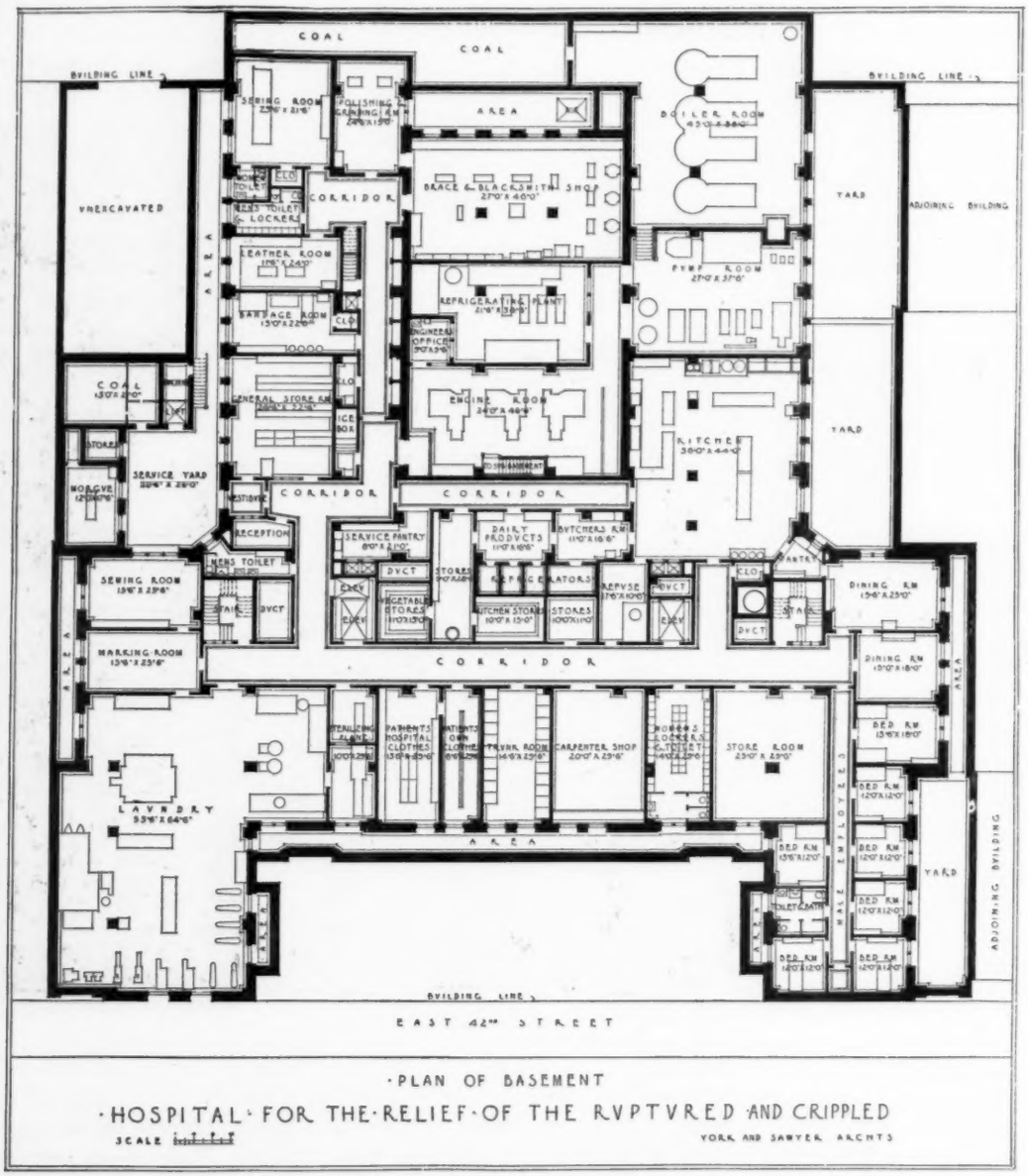

Fig. 5. Hospital for Ruptured and Crippled—Plan of basement.

The New York Society for the Relief of the Ruptured and Crippled furnishes medical treatment, braces, trusses, and bandages for every curable variety of deformity to the very poor, gratis; to others at cost of manufacture. The society fully realizes that, in spite of splendid

equipment, city life on the most spacious roofs, as an adjunct to cure of these physical defectives, is but a poor substitute for life in the country. While they are exerting every effort to secure funds for another hospital in the country, many charitable organizations are cooperating by receiving crippled children from this institution at Robin's Nest, Bath Beach, Sea Cliff, Aldrich Farm, and many other seaside and convalescent homes for the summer months.

A national organization, known as the Welfare Commission for Cripples, with many of our most prominent orthopedic surgeons on its membership roll, has existed for some years. Coordinate work for the cripples in New York received a decided impetus in 1913 by the organization of the Federation of Associations for Cripples. This federation, comprised of fifteen associations and societies of Greater New York, and cooperating with thirty-two other similar organizations, has launched a quarterly known as the "American Journal of Care for Cripples." The publication is edited by Douglas C. McMurtrie, with a staff of medical men as associates. Two numbers have appeared, and are not only attractive to the eye, but highly commendable from a literary standpoint.

At the last annual meeting of the Welfare Commission for Cripples the Journal was designated as its official organ, and the commission will cooperate with the federation in this wide field of usefulness.

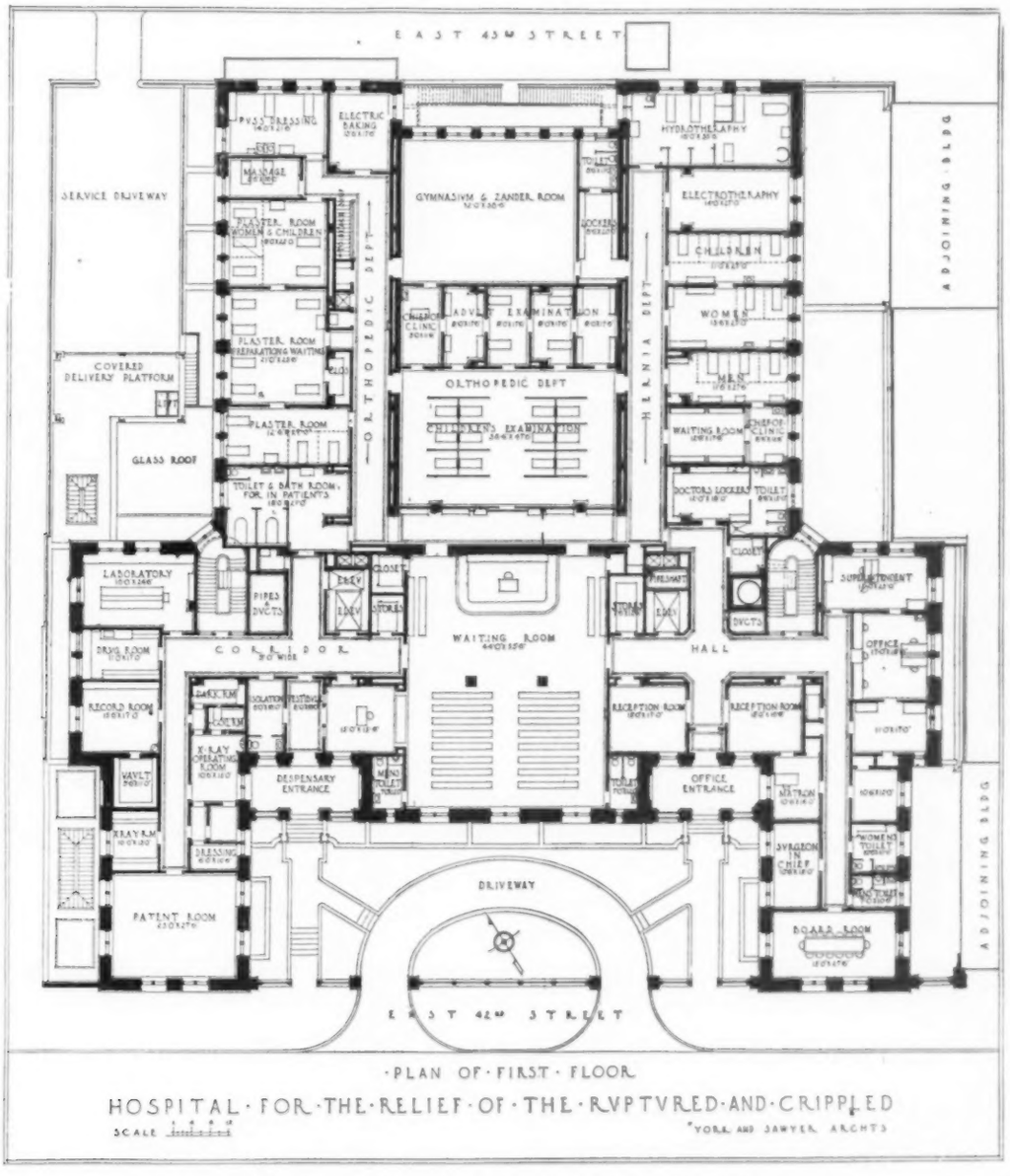

Fig. 6. Hospital for Ruptured and Crippled—Plan of first floor.

FEEDING THE HOSPITAL—THE FOOD.[1]

Vegetables, Cereals, and Fruits—Their Food Values, Methods of Preparation, and Cooking—Peculiarities of Each and Their Uses for Well and Sick.

By MISS LULU GRAVES, Dietitian Lakeside Hospital, Cleveland.

PAPER IV.

VEGETABLES, cereals, and fruits furnish us the necessary carbohydrate for the use of the body. The carbohydrate in vegetables and cereals is chiefly starch, and in fruits it is sugar. These food materials have very little fat, but are rich in mineral salts, and, with the exception of the cereals, have enough water in their composition to aid quite materially in supplying the needs of the body in that respect.

All of these food materials are obtained from plants—vegetables largely from the root, stem, or leaves; cereals from the seeds; and fruits are what the name implies. These plants are made up of innumerable cells, the walls of which are cellulose, with the starch grain inside. The older the plant, the tougher this cellulose becomes, and the hardness of this fiber plays a large part in the palatability and digestibility of vegetables.

If the vegetable be young and tender, it is at its best when cooked for a short time only and in a small amount of water. By this method a minimum of the salts is dissolved out and the sogginess of overcooked food is avoided, and in green vegetables the natural color is retained. If the vegetable be older, it requires a longer cooking in a larger quantity of water in order to break up the intercellular tissue and allow the starch grain to be reached. Older vegetables are apt to have lost some of their original water by evaporation, and it may be regained by this method of cooking.

The flavors also are affected by the method of cooking. Flavors are due to mineral salts and oils, many of which are volatile. If not properly cared for, these may be dissolved out in the water during cooking and thrown away, or escape in the vapors. In the case of strong-flavored vegetables, such as onions, cabbage, and turnips, this is desirable; or, when vegetables have been stored for some time, a strong flavor may develop which we prefer to partially lose. This may be done to a still greater extent if the vessel in which they are cooked be left uncovered. Many people have difficulty in digesting cabbage, cauliflower, and brussels sprouts because of the sulphur present, but they can eat these vegetables with impunity when the sulphur has been disposed of in the cooking. If the vegetables are fresh, the objectionable odor may be prevented from penetrating through the house by the addition of a piece of charcoal to the water during cooking, as the carbon will absorb the sulphur. On the other hand, chemical changes may take place when the heat and moisture are applied for cooking, in which flavors and odors are developed. This is true in cereals and a few starchy vegetables.

So much of the palatability and digestibility of our vegetables depend on their freshness and the method of cooking that we cannot make sweeping statements that certain vegetables are beneficial in certain diseases or conditions and harmful in others. A vegetable which is crisp and tender and has been recently brought from the garden may differ very materially in composition from the article which is served under the guise of that vegetable after it has passed through the treatment given in marketing, transportation, and cooking. A vegetable or fruit which must be shipped from its native place before ripening may not be used in some instances where a naturally ripened product could well be utilized. This is one of the points in favor of canned vegetables and fruits.

Green vegetables are much used in a raw state for salads and relishes, but the starchy ones should be cooked before being eaten. Boiling them cooks the starch and makes it more soluble; baking also does this, and to a small extent converts the starch into sugar.

Starch is a very stable substance, and vegetables with a high percent of starch may be kept in good condition for a long time; for that reason they may be had at any season of the year. Green vegetables are not so valuable from the standpoint of nourishment as the starchy ones, but they are nevertheless very valuable in the diet. They contain an abundance of mineral salts, which are very essential in metabolism. They furnish "bulk," which aids digestion; when fresh, they are appetizing and stimulate the flow of the gastric and saliva secretions. This is especially true of those which have a pungent quality, such as cress, mint, peppers, etc., and some of them are antiscorbutic in action. They are easily digested and give pleasing variety to the diet. Their food value is made greater by being served with butter or cream sauce if cooked, and by use of salad dressings or oil if served as a salad. With us the

[1] This is the fourth in a series of papers on "Feeding the Hospital." Last month, "Milk, Butter, Coffee, Tea, and Cocoa." Next month, "Meat, Poultry, Fish."

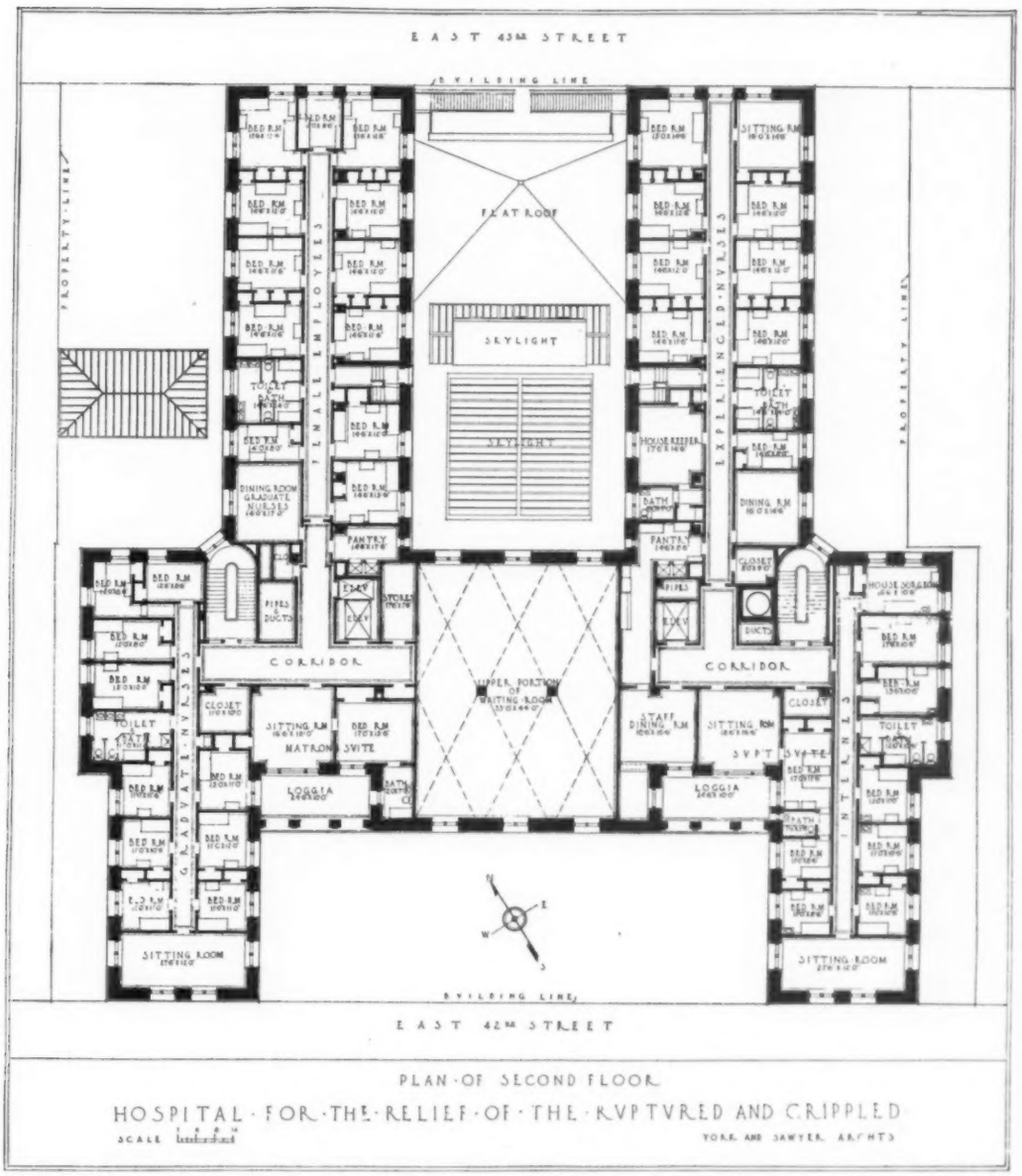

Fig. 7. Hospital for Ruptured and Crippled—Plan of second floor.

potato is a staple article of diet because it is inexpensive, has high nutritive value, and may be grown in almost all parts of the country. If properly cooked, it is easily digested; baking or boiling with the skin on prevents the mineral salts from being dissolved out and retains the potash, which lies next the skin. They should be pricked and the skin broken to allow the steam to escape if they have to be kept for a time or carried some distance before serving, as is apt to be the case in a hospital. If this is not done, as the potato cools the steam settles around the starch grain, making it soggy. Overcooking or keeping in a covered vessel after cooking will have the same effect. Potatoes are a bulky food, and should be used judiciously. New potatoes, like unripe fruit, have unripe starch, and should not be eaten by children or people with impaired digestion; on the other hand, old potatoes, particularly if they are allowed to sprout, have some of the starch changed to gums and sugar and become waxy.

Beets and carrots are other vegetables with a high percent of carbohydrate. They contain sugar as well as starch. When young, they are much more nutritious and readily digested than after the cellulose has hardened. Both have a characteristic flavor, and are desirable for salads or relishes as well as for a vegetable. Adding vinegar and other acid to beets softens the fiber. The leaves of the young beet are used for greens.

Onions and all vegetables belonging to the cabbage family are wholesome, but not especially nutritious. They contain mineral salts, some sugar, and much fiber. The strong flavor of onions is

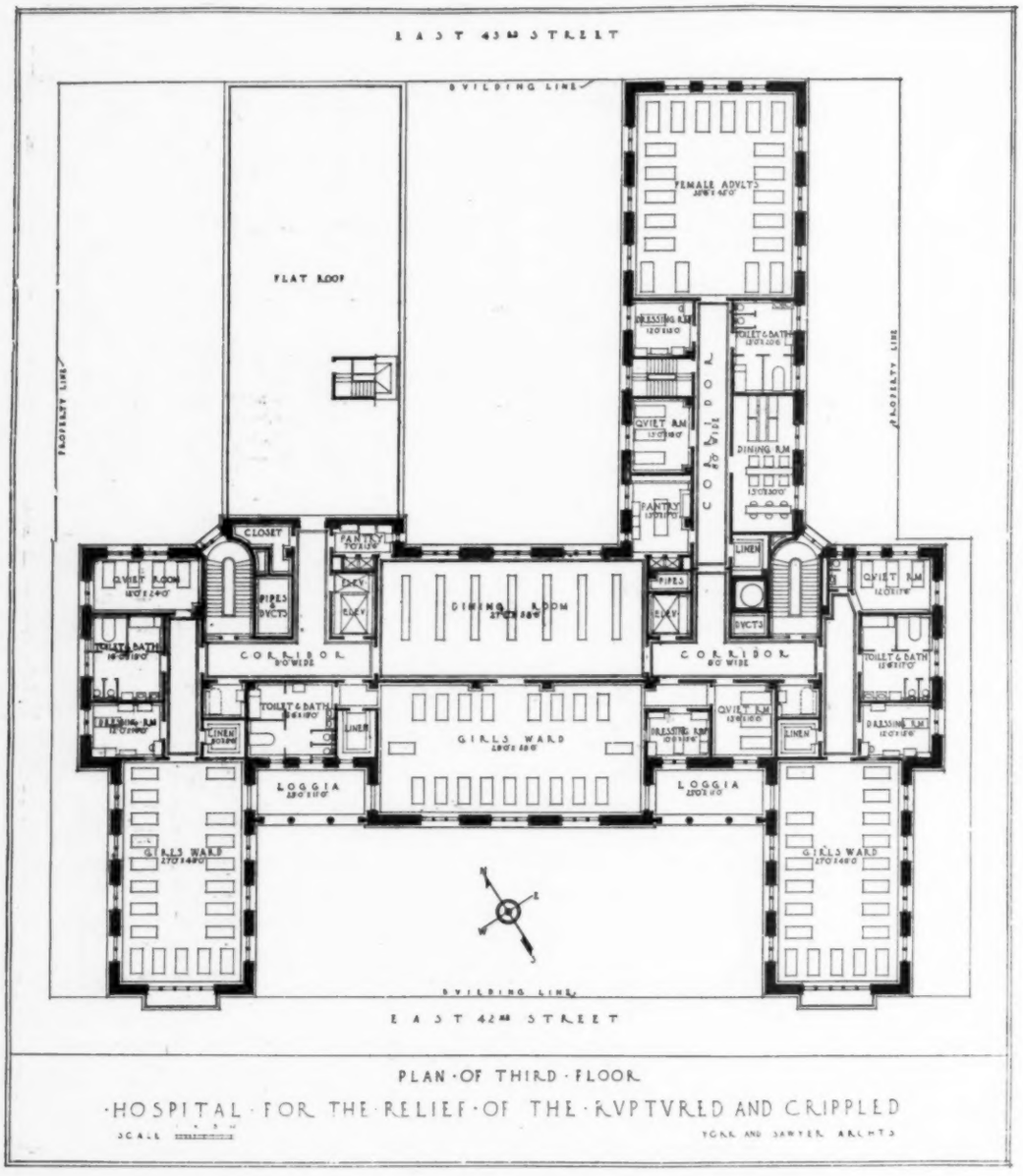

Fig. 8. Hospital for Ruptured and Crippled—Plan of third floor.

due to volatile oils, much of which may be lost in the cooking. They are utilized in soups, salads, etc., for their distinctive flavor. The Spanish and Bermuda onions have a much milder flavor than the others, and consequently are better liked as a vegetable.

All "head" vegetables—cabbage, cauliflower, artichokes—should be well washed and placed head down in a pan of water to which salt or vinegar has been added, in order to draw out any insects which may be hidden among the leaves. Thompson, in his "Food and Dietetics," says all foods should be well washed, not only for the purpose of removing dirt, but because of possibility of contamination from the water with which they have been watered or the fertilizer in the soil, and because the larvæ of the tapeworm and roundworm may adhere to their surface.

Tomatoes are in great favor as a food material because they may be served in so many ways, both cooked and raw—as soups, vegetables, salad, relish—and because they contain so many acids, which make them appetizing and an aid to digestion. Tomatoes and cabbage, when not properly cooked, may cause difficulties of digestion, which produce calcium oxalate in the urine. For this reason they should not be given to patients with gout or rheumatism.

Asparagus and artichokes are prized for their delicate flavor. Like all flavor foods, they are expensive because of the small amount of nourishment they contain. The form of carbohydrate in

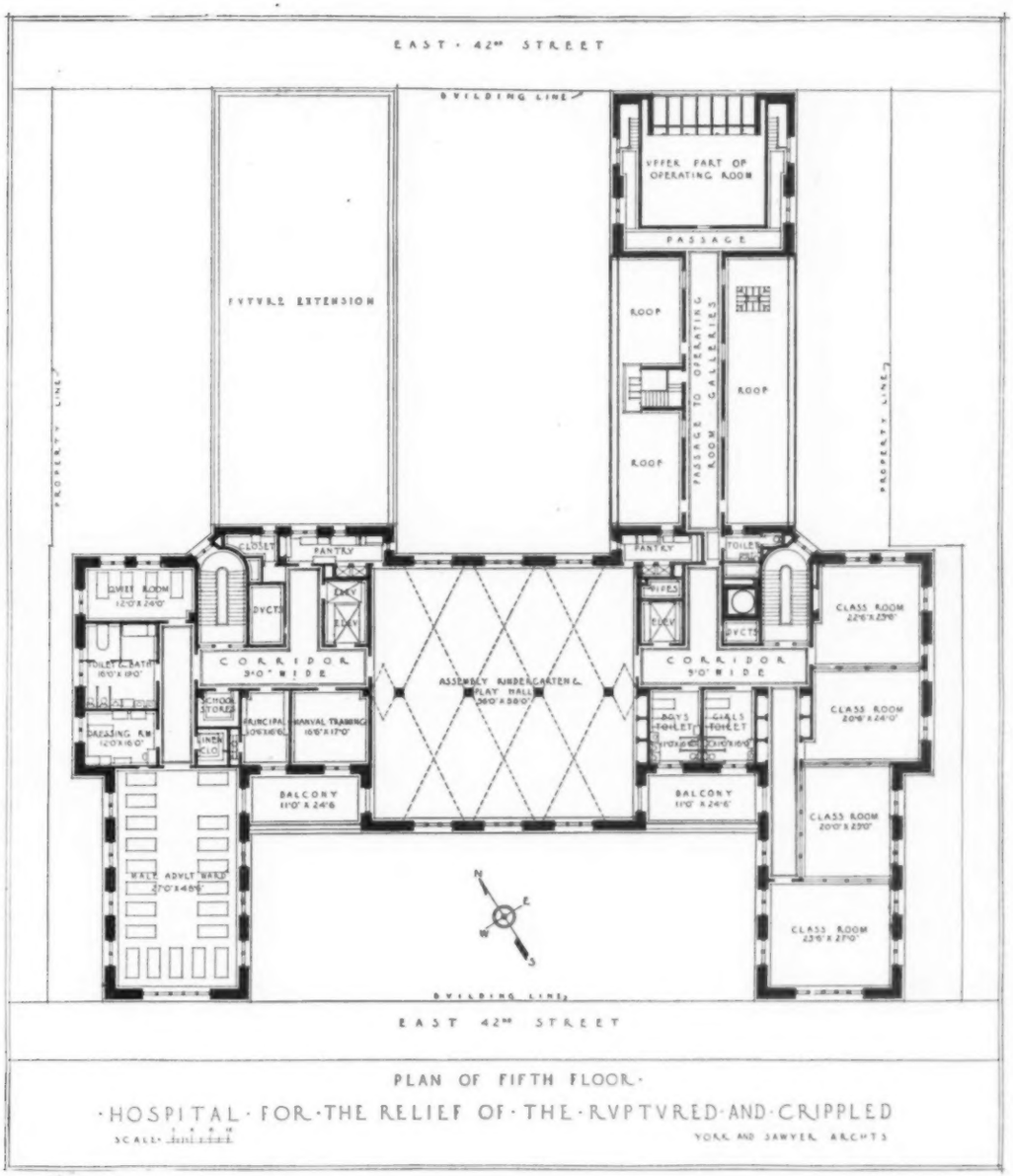

Fig. 9. Hospital for Ruptured and Crippled—Plan of fifth floor.

these vegetables is inulin. As this is not changed to sugar in digestion, they may be given to diabetic patients. Asparagus contains a substance known as asparagin, which has a diuretic effect, and also contains a high percent of purin, which is excreted by the kidneys in the form of uric acid. Lettuce and cress are chiefly cellulose and water, with very small amounts of protein and sugar, and acids and salts, which give them an aromatic flavor. For this reason they are liked as appetizers and to give variety to the diet. In this same class we might place celery and chicory; when blanched so that they are crisp and tender, they serve as relishes. Celery seed has a slight medicinal value, and celery salt furnishes a pleasing flavor for soups, sauces, stuffings, etc. The roots of the chicory are sometimes substituted for coffee.

In cereals and legumes we have all the nutritive constituents represented, though the fat is very low, and mineral salts not so numerous as in green vegetables; but the protein and carbohydrates are in large enough amounts to make them very valuable as food material. The protein differs somewhat in different cereals, but the value is much the same. They have another nitrogenous substance known as amides, which also varies, but is more abundant in the growing plant than in the seeds.

Corn and oats have more fat than the other cereals. Corn meal is rich in fat if the germ is left in the meal, but it becomes rancid much more

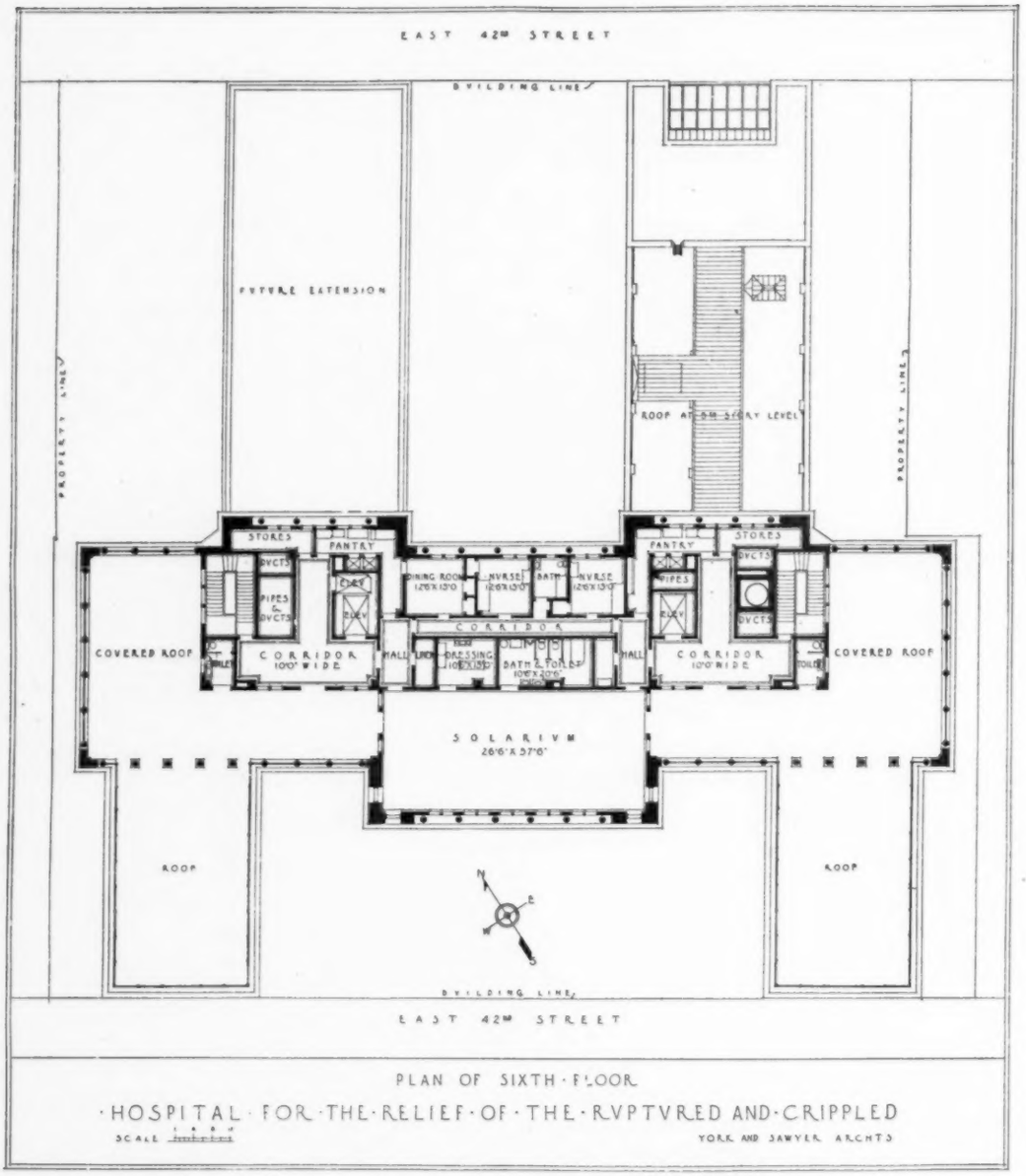

Fig. 10. Hospital for Ruptured and Crippled—Plan of sixth floor.

quickly. It has less nitrogen than the other cereals, and the refined product has lost much of its food value. In hominy the hull is removed, but all of the germ remains. This is not a popular cereal, but it is valuable from the standpoint of nutrition.

Both corn and oat cereals are known as "heating" foods because of the abundance of starch and fat present. Oats are either rolled or cracked. The manufacturers claim that the oats that have been heated and crushed between rollers require less cooking, but these claims are misleading, as they have not been sufficiently cooked. All cereals require long cooking in order to break down the intercellular tissue of the hard envelope which incloses the starch grain and make the grain itself soluble. A cereal containing the whole grain requires more cooking than one made from only the minor part of the grain. Much water is absorbed during the cooking of cereals, so it should be a slow process. Cooking overnight in a fireless cooker or a steam kettle at a very low pressure, if the quantity is very large, is the best way to thoroughly cook the cereal and develop the flavor.

Wheat is the most widely used cereal. It is ground and part of the outside removed in making Cream of Wheat and Farina; it is rolled and the whole grain used in making Pettijohn; dextrinized, and with malt or honey added, it is Grape Nuts; ground and bolted, it is made into flour of various grades, according to the process of manu-

facture, ranging from "Patent" to Graham. "Whole wheat" flour is a misnomer, as the outer covering is removed in making this flour. We have gluten flours on the market which claim to have all or nearly all of the starch removed, but they are not to be relied on. After making or having made tests of every brand of gluten flour obtainable in Chicago and a few other places a couple of years ago, we found none that was safe to give to a diabetic patient. Our conclusions have been confirmed by tests made at the University of Chicago.

Macaroni, spaghetti and noodles are made from the hardier varieties of wheat. They are also rich in carbohydrates and proteins, and are almost completely absorbed in the body. When combined with cheese, tomato, bacon, or milk, they make a most nutritious and economical food.

Rice is widely used for people with weak digestion, though it is not particularly easy of digestion, and the cooking of it is a most important factor with regard to its palatability and digestibility. It is very well absorbed, however, and is so low in fat that no difficulty occurs from that source.

We have on the market a number of so-called "prepared" breakfast foods which are palatable and nutritious, but expensive as compared with the other kinds. Their manufacturers claim for them that they are cooked and predigested by malt or other preparations, but, as a matter of fact, they do not have enough malt to sufficiently digest them, nor is the dextrinization sufficient in the brands that are "predigested" in that way. If they were sufficiently done, it would be no advantage to the healthy individual to have his food digested outside of his body and thus deprive his digestive organs of the stimulus given by the grain. Only a much impaired digestive tract could be benefited by it.

Other carbohydrates which are of high food value, easily digested, and well absorbed are tapioca, sago, and arrowroot. As a general thing, these are combined with milk, egg, or fruit juices, which add to their desirability both as a food and for the flavor.

Legumes have a higher percent of protein than cereals, but they are less completely digested, and the flavor is not so well liked as a rule. As a source of protein they rank next to meat and eggs in importance, and are much used by vegetarians. Fresh green peas and beans are easily digested, but when they are old they are hard to digest unless they are cooked a long time. Dried legumes are tough, and should be soaked for several hours before cooking. It is said that legumin and salts form an insoluble compound which cannot be made soft, which means that peas and beans should not be soaked nor cooked in water that is very hard. If cooked with pork, their food value is very much increased and the combination is more palatable. Legumin is sometimes referred to as vegetable casein because of the similarity to casein in milk in its composition and action.

Kidney beans cost less and are more popular with people who do hard physical labor. Lima beans are very wholesome, and more popular with those who have less hardy appetites. Soy beans are used much in the Orient, but are not fully appreciated here. Soy bean flour is used in preparations for infant feedings to some extent.

Another legume not properly appreciated is the peanut. It has both fat and protein in large percentage, has an agreeable flavor, and may be utilized in many ways. During the roasting process, which is the method of cooking peanuts, the flavor is developed. They furnish an extremely well-balanced food. Dr. Hall, of Northwestern Medical School, says that peanuts and apples, if properly masticated, will sustain life for a long time. Meal made from peas and beans may be had at a moderate cost, and is very good for thickening soups, making gruels, etc., though a puree of vegetables is better for cream soups. Often when the digestive organs are not equal to the task of disposing of vegetables and cereals which are served in the ordinary way, they can easily take care of the strained cereal of vegetables.

Gruels, purees, and cream soups are extremely nourishing, and logically follow the milk-and-broth diet when a patient is able to utilize them and the "building up" process begins. Another advantage is the variety of ways in which they may be served, which leaves no excuse for a monotonous diet when this stage is reached. Gruels prepared from thoroughly cooked oatmeal, served plain at one time, with cream at another, a well-beaten egg at another, with beef tea or beef juice, make a goodly number of changes, which may be followed by rice or farina gruel, with the same variations, and fruit juices or sherry in addition. Prune juice is especially good with these gruels; these, with broths, custards, and gelatins, give a wide enough range to prevent frequent repetitions, and can be managed even in large hospitals if there is the proper cooperation between the medical men and the kitchen.

Fruits are held by some people to be a luxury rather than a food; to be of dietetic value does not necessarily mean that a food must build tissue or furnish heat. The sugars in fruit do furnish some heat and energy, but fruits perform other functions equally important. They introduce into the system salts and organic acids, which improve the quality of the blood and react favorably on the

secretions; they serve as diuretics, laxatives, and antiscorbutics; they are refreshing, stimulate the appetite, and convey water into the body; they add a pleasing variety to the diet—not to mention their usefulness as a foundation for special cures and fads, such as the grape cure, etc. The delicious flavors of fruits are produced by compounds known as ethers in combination with the sugars dissolved in water, and the acids. There is no starch in ripe fruit, except in the banana. The acids are quite similar to each other, and all are organic; therefore they can be utilized by the body. The three most common are citric in lemons and oranges, tartaric in grapes, and malic in apples. These are typical acids, though most fruits have several kinds. Citric and tartaric acids are separated from fruit and used commercially for many purposes. Pectin and pectose are other forms of carbohydrate in fruits, and are the properties which cause the juice to "jelly," when boiled in the presence of the acids and sugar of the juice. Apples, grapes, and plums have a comparatively large percent of pectin and pectose, and are consequently more easily made into jelly than berries and many other small fruits.

A judicious use of fruit in the diet is very beneficial, the only danger being in the use of green or decayed fruit. Cooked fruit is safer than the uncooked, especially if overripe or not well ripened; the starch which may be present in green fruit is made soluble by the cooking, and the overripe may have bacterial action begun, which will be checked by cooking. Chemical changes occur in the presence of heat, which neutralize the acids and give different flavors.

Fresh fruits are well adapted to our needs in summer on account of their low caloric content as well as for reasons given above. Lemons and oranges are generally available, and they are agreeable to nearly everyone, qualities which make them most useful in the sick room. They may be used to encourage the consumption of water in renal disorders, or in any condition where much water is required. Made into ices and sherbets, they are less likely to disagree than ice cream, and are very refreshing to patients with a high temperature. A slice of lemon in the mouth will remove the disagreeable taste due to a coated tongue. Lemons and limes are valuable antiscorbutics owing to their vegetable acids, potash, and other salts. Pure lemon juice poured into the nose may often control epistaxis. Figs, prunes, apples, and berries have enough sugar to make them of high food value, and their seeds, skins, and fiber make them helpful as laxatives. Pineapple is not only appetizing and refreshing, but contains an enzyme which aids in the digestion of protein. A common proof of the action of this enzyme is found in the rapidity with which it will digest gelatin, a proof that many a housewife has had when trying to prepare a gelatin dessert with raw pineapple. With the exception of oranges and lemons, no other fruit is so beneficial in the diet of the sick. Some of our eastern physicians are finding pineapple juice very effective in cases of anorexia, and it is a rather unusual thing to find a patient in a hospital who will not enjoy preparations of pineapple if they enjoy any food at all. Bananas and pears are much more easily digested if cooked, particularly if baked; they are more readily broken up by the digestive juices, and flavors are developed which change the original taste very much.

Mastication plays a very important role in the digestion of fruits; bananas, melons, grapes, and blueberries are very apt to slip down the throat whole or before being finely chewed, thereby putting too much of a tax on the digestive organs.

Fruits are preserved by means of cold storage, and may be kept in excellent condition provided the temperature does not go below freezing. Preservation by drying is an inexpensive way of keeping fruit, and does not affect the food value to any extent, except in the loss of water; this is remedied by soaking the fruit before cooking for a sufficient length of time to allow the reabsorption of an amount of water equivalent to that which was evaporated in the drying process. As the drying process requires a great many hours, the soaking process should also be allowed to go on for several hours. In the commercially dried fruits sulphurous acid is used to prevent discoloration, as the fresh fruit is exposed to the sulphur fumes before drying. Some of the sulphurous acid escapes with the moisture, but enough remains on the fruit to have called forth a protest. There is probably not enough sulphur remaining to harm a healthy, normal person, but there is possibility of a weak digestion being affected by it. Here again the method of cooking is an important feature in the palatability and digestibility. If dried fruit is thoroughly washed, sufficiently soaked, and not overcooked, it may be made very appetizing, and is available for those who cannot afford the fresh fruit. Canned fruit has as much to be said in its favor as may be said of any cooked fruit. Since our canning factories are being managed on such efficient and sanitary plans, there may be some advantages in using fruit or vegetables which are canned in the same section of the country in which they are grown. They may ripen before being gathered and are not subject to the deterioration due to transportation, standing in open markets, and much handling, which our fruit is

apt to receive before reaching us unless it is grown in the vicinity. Canners have better facilities for sterilization and for keeping their fruits and vegetables whole and in good condition than our homes can possibly have. They get the product when it is in the best condition for canning; their scientific investigations in their own laboratories have taught them the exact temperatures that are best for each material, how to gauge density of syrups, and all other important points in preservation by canning.

Both fruit and vegetables being put on the market today by our best factories are as wholesome as the home product, and perhaps have been selected with more care than some of our home products.

THE NEED OF BETTER HOSPITAL EQUIPMENT FOR THE MEDICAL MAN.[1]

American Institutions Provide What Surgeons Need, But Neglect the Agencies Required by the Practitioner of Medicine—A Plea for Hydrotherapy and Physical Therapy Installations.

By EDWARD F. STEVENS, Boston, Member of American Institute of Architects.

As one visits the more or less modern hospitals of the United States, he will generally find beautiful operating suites, with modern plumbing, equipment, and instruments, the best that science has developed, in order that the *surgeon* may do his best work. But what do we find for the medical branch of the staff? A medicine closet for drugs, the ordinary bath tub two-thirds the length of the patient, the hot-water jugs and compresses, and a more or less up-to-date x-ray outfit. That is generally the extent of the equipment. How much longer will the medical men stay quiescent and allow their brother practitioners who have taken up the surgical side of the profession to get all the equipment, all the choice rooms, all the plums? Shall we go on building our hospitals without thought of the medical man, or shall we devote a little space for his needs?

Are the builders of the great modern public hospitals of Europe wrong in their theory and practice? For in every modern public hospital on the continent one will see the great medical department building or bath house equaling, and generally surpassing, the "operation" building in size and equipment. Unless this means the relief of human suffering, would the German, the Danish, and the Dutch governments spend the vast sums they appropriate for this splendid equipment? Or are all these departments mere fads and fancies of a few influential members of the staff, who wish to work out some new theory? This might be true in one institution; but would it be repeated in all of the newest institutions, each one a little more complete and far-reaching than the others? For one will find in the medical department such sections as mechanotherapy; hot air, warm, steam, light, electric, gas, radium, sand, sulphur, mud or peat, and sun baths; inhaling and pneumatic chambers; roentgen ray, with all its ramifications.

To the student of hospital architecture the question naturally arises, If these methods of treatment are essential for the well-being of our neighbors, poor and indigent, across the sea, why should we not practice them, or some of them, in our institutions? Just to show what some of the later European hospitals are doing along the line of medical equipment, I will refer to a few examples.

The Eppendorf, at Hamburg, is not now considered one of the newest hospitals, but has devoted a proportionally large space to the medical treatment building.

The Virchow, at Berlin, devotes even more space to this department than to the surgical.

In the St. Georg, at Hamburg, while the bath house is not so large in proportion, it is several stories in height and most complete in equipment.

At the Barmbeck, Dr. Ruppel's latest hospital, at Hamburg, the bath house is given the place of honor on the main axis, while the operating pavilion occupies a secondary position.

Bispebjerg, at Copenhagen, the newest large Scandinavian hospital, has devoted a large space to this department, which is entered by semi-underground passages.

In Munich-Schwabing (Fig. 1), one of Germany's best hospitals, one will find a most complete equipment. If we study this plan in detail (Fig. 2), we will find baths of every kind for the relief of suffering humanity. Commencing at the left is the roentgen ray department, the inhalation department, the rest rooms, pneumatic chamber, massages, and mechanotherapy; and in the center the various baths are arranged—the Fango or Italian volcanic earth bath, the mud or peat bath, sand bath (where the sand is heated and applied to the patient), the gas and electric light

[1]Read at the sixteenth annual conference of the American Hospital Association, St. Paul, August 25-28, 1914.

baths; the general hydrotherapeutic room, with its spray bath of every description, its warm and cold plunge, its wading bath—all of these placed in a most magnificent room (Fig. 3). On the second story of this building is the great sun bath room, so arranged that, if the sun is too warm, the surface of the glass can be covered by a water curtain, as it were, thereby reducing the temperature of the room.

In this hospital I first saw the pneumatic chamber used for treatment. A patient needs rarefied air, and is sent to the hospital. He is placed in one of these rooms, surrounded by his books and papers. Pressure in the room is reduced to the desired amount, and the patient receives at home the rarefied air of the high mountains; or perhaps he is ordered a greater than atmospheric pressure, in which case the chamber is put under pressure instead of a vacuum.

The water bed (Fig. 4) is used for the relief of many troubles, and is considered one of the indispensable pieces of equipment. At the St. Georg I saw one poor fellow in this water bed, who had been for months in this position, eating, sleeping, and reading, and who could not have lived under other conditions. The water bed, or full-length tub, with adjustable hammock, one will see in many wards in Germany and Austria. In one hospital that I visited each medical ward had its water bed, and in other wards each bed was provided with pipes from the wall for cold water circulation in place of ice caps.

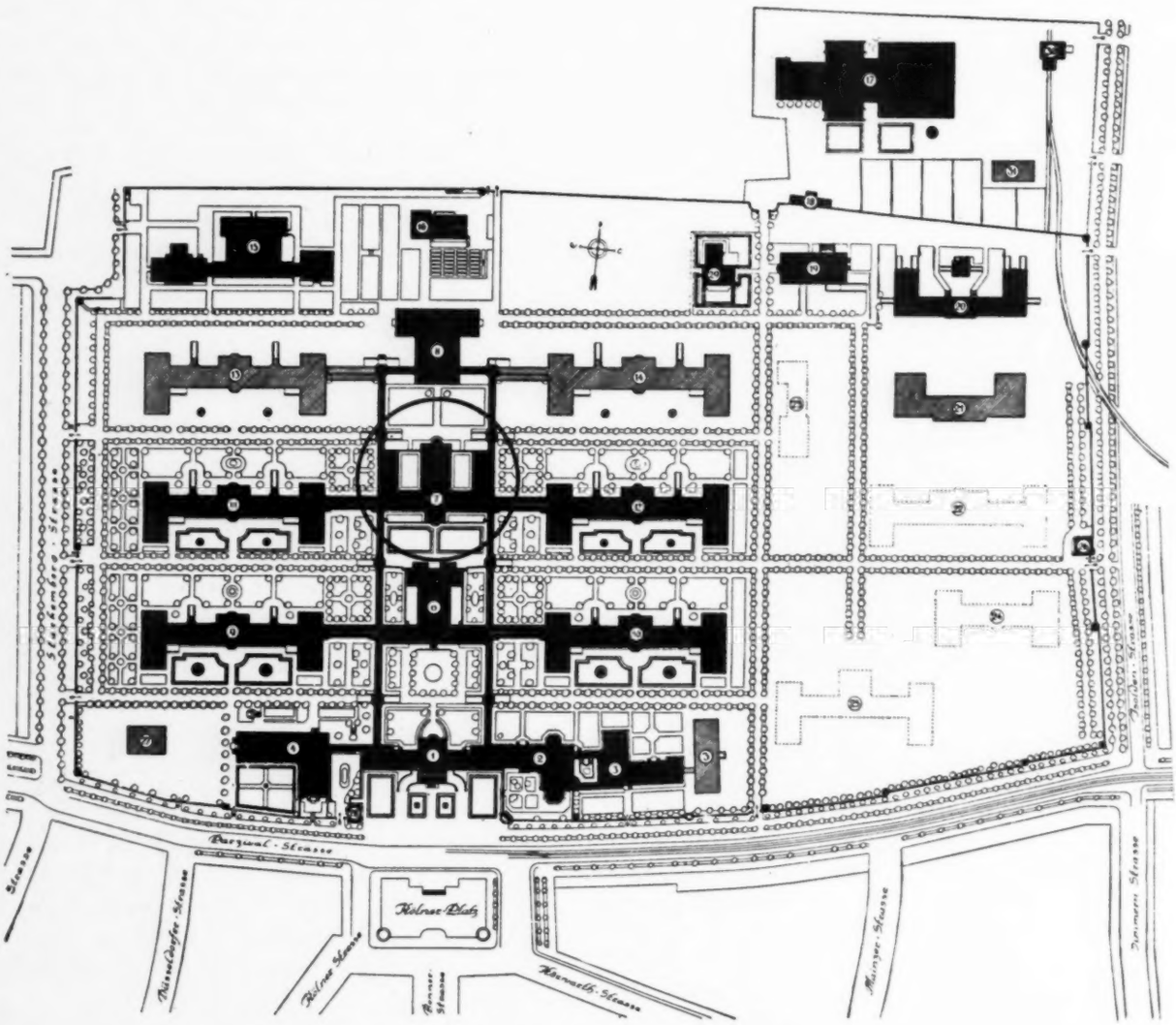

Fig. 1. München-Schwabing Hospital—Ground plan.

1. Main building.
2. Chapel.
3. Sisters' building.
4. Administration building and apothecary.
5. Benzine building.
6. Operation building.
7. Main bath.
8. Kitchen.
9. Male out-patients' building.
10. Female out-patients' building.
11, 13. Male patients' buildings.
12, 14. Female patients' buildings.
15. Disinfecting building and laundry.
16. Garden and workshop.
17. Machinery building.
18. Animal experiment building.
19. Pathological building.
20. Segregation building.
21. Contagion building.
22. Skin and sex disease building.
23. Mental disease building.
24. Children's building.
25. Gynecological building.
26. Janitors' quarters.
27. Director's residence.
28. Public lavatory.
29. Main administration building and residence.
30. Coal house.
31. Building for help of electric plant.

The sand bath (Fig. 5), where the patient is packed in sterile sand at the proper temperature, is found in almost every large European hospital.

The hydroelectric bath, the carbon dioxid bath, the plunge, and those mentioned before are just a few of the examples one will find in the general public hospitals of Europe. I am not referring now to the various sanatoriums which one finds all over the world, but to the general hospitals for the care of the poor and indigent. Should we not in America provide such equipment, that the patient suffering from arthritis, chronic rheumatism, or cellulitis, might have the proper mechanical, electrical, heat, and massage treatment, or the water bed for severe bodily burns or sores?

Should we not provide separate accommodation for the psychopathic patient? Why should we send our contagious and tubercular cases to separate institutions when, with proper equipment and segregation, which can be afforded in the general hospital, these cases can be taken care of with greater economy under one administration than under many?

Nearly every large hospital has some of these equipments, and few modern hospitals are built without the airing balcony, where the medical as well as the surgical patient may have the fresh air and sun treatment. There are few hospitals in the world which have a more complete mechanotherapy equipment than the Massachusetts General Hospital, at Boston, in its splendid Zander room (Fig. 6). But even here the service is largely that of the surgical side.

Today nearly every hospital, large or small, has its roentgen or x-ray outfit, and in many a more or less complete hydrotherapeutic department is provided.

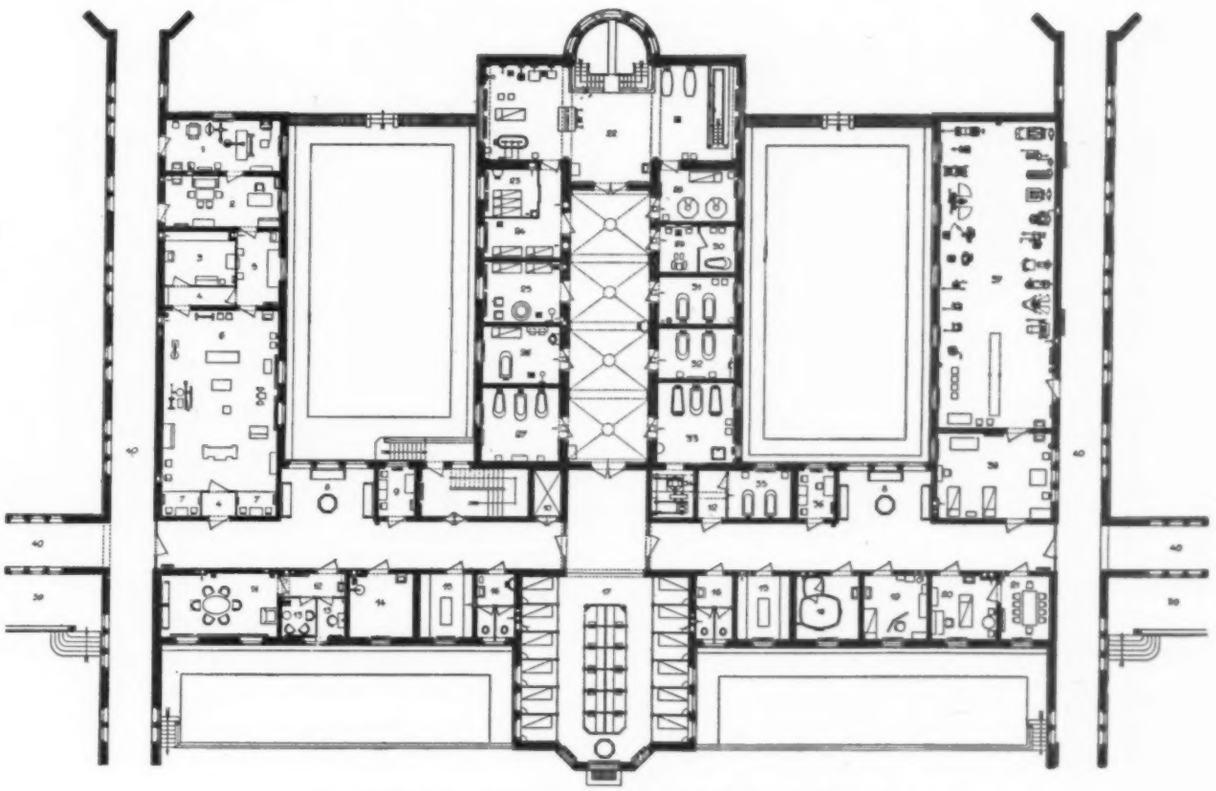

Fig. 2. München-Schwabing Hospital—First floor plan. Main bath.

1. Roentgen therapeutics.
2. Phyicians' room.
3. Dark room.
4. Light shaft.
5. Photograph laboratory.
6. Roentgen room.
7. Undressing room.
8. Waiting room.
9. Attendants' room.
10. Elevator.
11. Social room.
12. Ante-room.
13. Segregated room.
14. Light bath.
15. Wash room.
16. Toilet.
17. Rest room.
18. Pneumatic room.
19. Examination room.
20. Physicians' room.
21. Ante-room.
22. Douche room.
23. Hot air bath.
24. Warm air bath.
25. Vapor room.
26. Fango mud bath.
27. Mud bath.
28. Heat bath.
29. Four-cell bath.
30. Electric water bath.
31. Gas bath.
32. Salt water bath.
33. Sand bath.
34. Sand room.
35. Sulphur bath.
36. Female attendants' room.
37. Therapeutic gymnastics.
38. Massage room.
39. Rest room.
40. Hallway.

With the knowledge of the therapeutic value of the various treatments employed abroad, why do not the American hospitals grasp the opportunity to relieve our fellowmen? Is it because our medical schools and our teaching hospitals have not awakened to these possibilities? Or have our American medical men some more simple method of treatment?

In my discussions with various medical specialists, they acknowledge the value of equipment and recommend it where possible, especially the

full-length continuous bath or water bed, the hydrotherapy, and baking. In the later hospitals in which I have been interested I have endeavored to set apart certain rooms and reserve them for the medical treatment rooms, having reason to believe that within a very short time the medical men will require equipment commensurate with the needs of their profession.

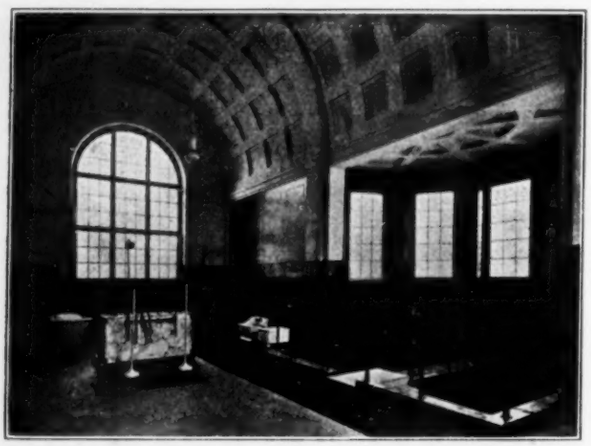

Fig. 3. München-Schwabing Hospital—Douche room in main bath.

In the new St. Luke's Hospital (Fig. 7), at Jacksonville, Fla., about one-half of the second story of the administration building is set apart for medical treatment. This portion is not equipped, but is ready whenever the demand comes and the funds necessary to equip and maintain it are obtained.

In the plans of the private pavilion of the Royal Victoria, at Montreal, a large space is to be set apart for medical equipment, a small psychopathic department, roentgen ray department, hydrotherapy, electric, Nauheim, and continuous baths, and rest and massage rooms.

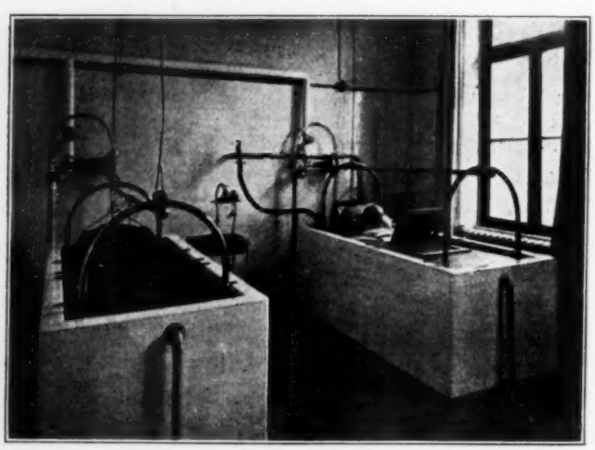

Fig. 4. Water beds (continuous baths) at St. Georg Hospital, Hamburg.

At the new Ohio Valley General Hospital, at Wheeling, a complete isolation department is built on the fifth floor, entirely isolated from the main hospital by cross fresh-air passages, with separate serving kitchen and sink rooms, airing balcony, etc. Every room is completely equipped

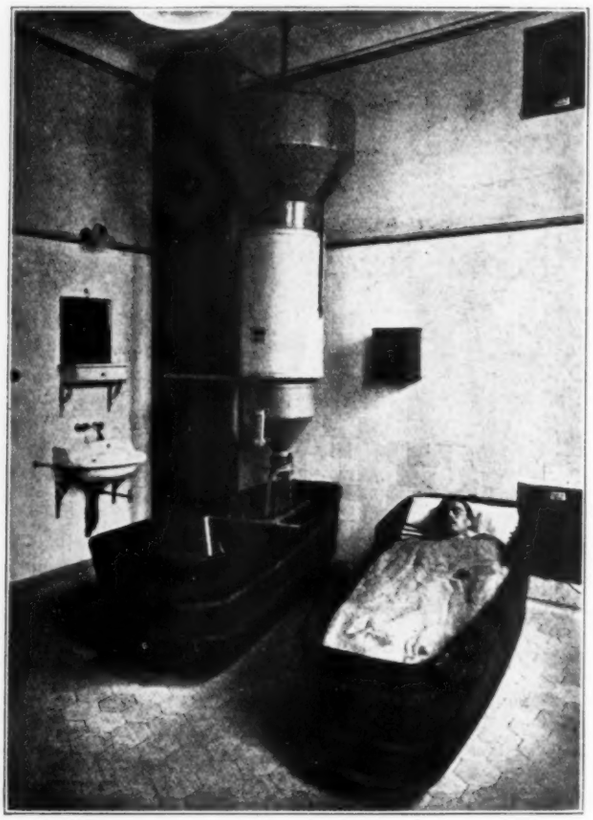

Fig. 5. Sand baths at St. Georg Hospital, Hamburg.

with sinks having elbow faucets, doors without knobs, but with hook handles on the inside for opening with arm or elbow. In this department the individual bath is given in a shallow tub,

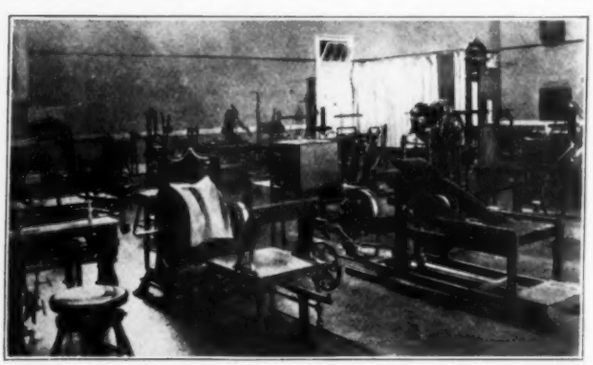

Fig. 6. Zander room at Massachusetts General Hospital, Boston, Mass.

placed on wheels, so that the top of the tub is level with the bed. Floor connection is established with the waste pipe, and the patient is given a spray bath with clean water.

At Mount Sinai Hospital, New York, the physicotherapy department, under Dr. Wolf, is doing splendid work for the relief of many.

The help given to the so-called chronic invalids at the New Robert Brigham Hospital, Boston, by

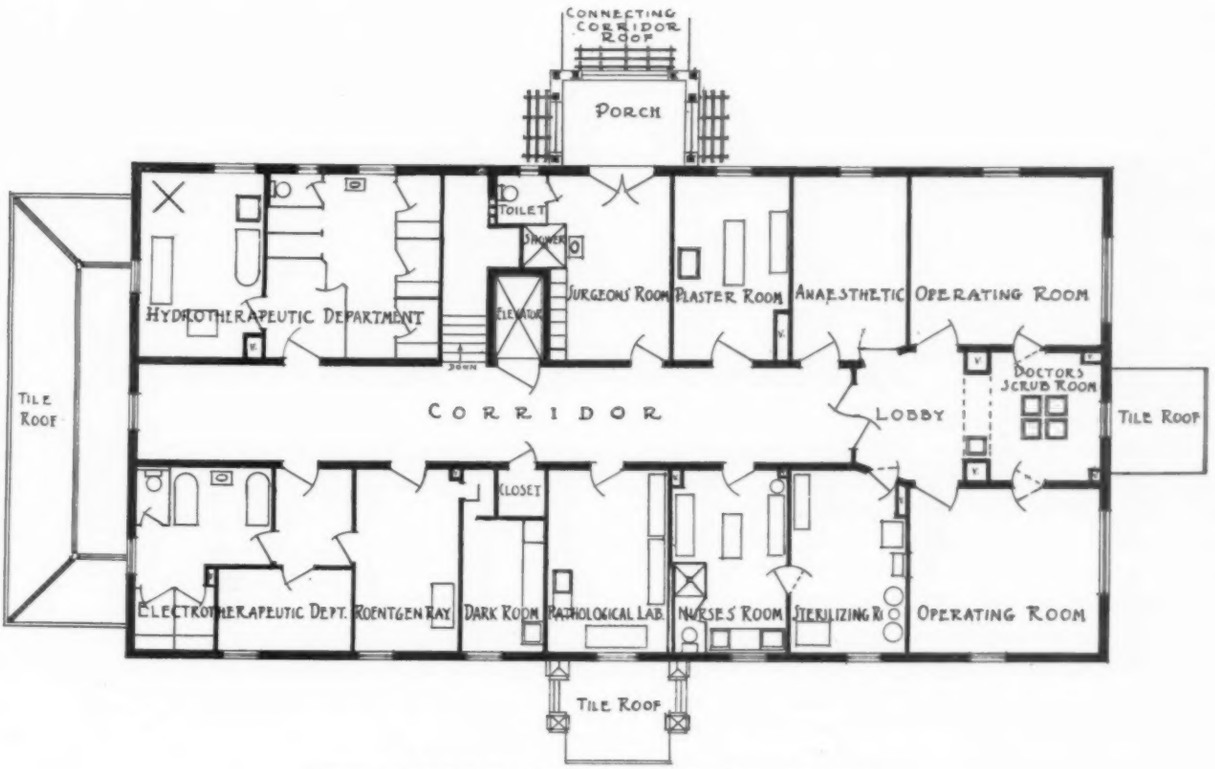

Fig. 7. St. Luke's Hospital, Jacksonville, Fla.—Second floor plan.

scientific treatment is referred to as little short of miraculous.

I have mentioned only a few cases where the medical man is being considered in the planning of new hospital buildings, and I hope the discussion will bring out others and that you will tell us what we should provide.

Preventive medicine and treatment is much discussed. Will not the medical or bath house department, with its many treatment and rest rooms, soon be as important a factor in our modern hospitals as our operating department is today?

HOW AN AVERAGE COMMUNITY CARES FOR ITS SICK.[1]

Amount, Character, and Care of Sickness in Selected Urban and Rural Districts in Dutchess County, New York.

By JOHN R. SHILLIDAY, State Charities Aid Association of New York.

THE story is told of how after the French occupancy of Algiers a census of the country was to be taken according to modern standards. The French officials requested information of an ancient Mohammedan sheik as to the number of inhabitants of his territory, to which the reply was, "Allah alone knows." To the second question, as to how many of them died and of what diseases, was given the same answer, with the addition, "It would be impious to inquire." While we have in this country passed far beyond the standard of the Mohammedan sheik, it would still be proper, if one were asked how much sickness there was, to reply very much in the words of the Algiers official, "Allah alone knows." What is very much needed is definite and reliable information as to the amount and character of sickness in various parts of the country and under various conditions, and just what is being done about it. It may not be presumptious, therefore, to believe that the results of a study of sickness in four towns and part of a city in a typical county in New York State, with no special problems peculiar to itself, may be of interest and value to all stu-

[1]Read at the sixteenth annual conference of the American Hospital Association, St. Paul, August 25-28, 1914.

dents of problems involving the care of the sick and the prevention of disease.

PURPOSE AND METHOD.

At the request of the Thomas Thompson Trust, an organization primarily interested in the improvement of social conditions and actively working in Rhinebeck, Dutchess county, N. Y., and in Brattleboro, Vt., an attempt was made by the Hospitals Committee of the State Charities Aid Association to secure reliable data relative to sickness which occurred in certain selected communities in Dutchess county during a sixteen-months period of 1912 and the first four months of 1913.

A trained investigator was employed to secure, directly from those families in which it had occurred, as full and accurate data as possible concerning sickness, including the medical and nursing service obtained, its efficiency and cost, the need of and demand for domestic assistance in the homes where sickness occurred, and the efficiency with which such demand was met. Detailed inquiry was made into family conditions, including the names of the members of the family, their ages, occupations, general economic status, mental and physical condition. The attending physician was consulted either personally or by letter about each recorded case of sickness. In this way the facts obtained have been checked up, and the medical viewpoint as to the character of the sickness and the adequacy of the care has been ascertained. Only one physician out of fifty-nine refused his cooperation, maintaining that sickness was a private matter of no public concern. The viewpoint of the family of each patient was ascertained as to the treatment received, together with their opinion; if they believed the care to have been inadequate; as to what services, whether hospital or home, would have been necessary to have secured adequate care. The time spent in hospitals, the cost of hospital care, and the time sick and the cost of such illness were also recorded.

It was not always possible to learn the cause of the sickness recorded. The family seldom had any idea of the cause, and was often vague as to the exact duration of the illness. The physicians in the rural sections, especially, were equally vague. Their records were found usually to consist of the number and cost of the calls made, and, if the bill had been met, even these scant data had usually been destroyed. There was little difficulty in securing information from the families, publicity through the local press assisting in that.

FIELD COVERED.

The investigation was made in the towns of Rhinebeck, Stanford, Milan, and Clinton, and in the Fourth Ward of Poughkeepsie. The towns covered (contiguous to each other) are typical rural communities, with a total population of about 7,223.

Stanford is a county town of about 1,520, of whom 700 live in two adjoining villages.

The towns of Milan and Clinton are typical farming sections. Milan has a population of about 893, and Clinton of 1,278. Stanford has one resident physician, who acts as health officer. Milan is without a resident physician, and Clinton has three. In none of these towns is there district or school nursing. As in the majority of rural communities, the water supply is drawn from private wells. A relatively small number of houses are connected with cesspools. The others still have only surface drainage and the old-fashioned privy, with a dug vault.

The population of Rhinebeck town is approximately stationary. The 1910 census shows a total of 3,532, an increase of but 165 over that of 1890. About 1,548 of this population live in Rhinebeck village and about 600 in the village of Rhinecliff. The village of Rhinebeck is given over largely to violet growing. District nursing, maintained by the Thompson Trust, is carried on under the supervision of the matron of Thompson House, but, because of the difficulty in obtaining an efficient woman for such work in the country, school nursing has been, until the winter of 1913-1914, somewhat intermittent since its first introduction into the community in November, 1911. There is close cooperation between the trustees of the Thompson Trust and the county agent for the care of dependent children of the State Charities Aid Association.

In the village of Rhinebeck private cesspools are found in relatively large numbers. The old-fashioned privy vault is, however, still in existence in a number of cases. This is especially important when it is taken into consideration that, although the water supply can be drawn from sunken wells (owned by private corporations) at a distance of about three miles from the village, private wells are still used by a relatively large number of the population.

The village of Rhinecliff is built on a steep slope. There is no system of drainage there, and the water supply is drawn from wells. Street drainage is discharged into the river. In the town outside of the villages of Rhinebeck and Rhinecliff there are the privy vaults and surface drainage which characterize most rural communities.

Poughkeepsie, with a population of 28,500, is the chief center of the western section of the county. The Fourth Ward of this city was selected as being more typical of the city as a whole than

any other one ward. Based on the average increase in population for the last ten years, the population of this ward is approximately 4,580 (16 percent of that of the city). It includes a representative part of the main business section of the city, a wealthy residential section, and a fairly proportionate number of the homes of the poor and of those of moderate means. The ward contains an average number of the colored and foreign population of the city. Poughkeepsie sewage is emptied into the Hudson river. The water supply is drawn from the Hudson river, but there is a filtration plant connected with the system. A district nurse, the only one in the city, is maintained by a private society. This nurse also does nursing for the Metropolitan Insurance Company. A tuberculosis nurse and a babies' welfare nurse are maintained by the local board of health. A nurse (untrained) cooperates with the school physician in working with the school children. The Associated Charities and the Home Missionary Society, as relief agencies, come in close touch with the sick poor. A county agent, supervised by the State Charities Aid Association, is meeting the varied problems involved in the care of dependent children.

Aside from a public tuberculosis hospital of 100 beds and a small hospital maintained by the city in connection with the City Home (almshouse) for the inmates of that institution, the hospitals of Poughkeepsie are private. One has a capacity of 67 beds, one of 12, another of 14, and there are 11 beds available in another—a total general hospital provision of 104 beds.

In February, 1914, an additional hospital was opened for the reception of a small number of patients. The plans allow for a capacity of about 70 beds, not including the provision which will be made for contagious cases; 15 beds will be available for obstetrical cases, and 25 for children. Including these 70 beds, which are assured (and omitting the hospital for tuberculosis), Poughkeepsie will shortly have a total capacity of 174 beds.

In the Fourth Ward of Poughkeepsie and in the town of Rhinebeck, including the two village corporations of Rhinebeck and Rhinecliff, a house-to-house canvass was made to inquire of every family concerning cases of sickness during the period covered. As the time allowed for field work was limited, it was impossible to make a house-to-house canvass elsewhere, and in the towns of Milan and Clinton a family was omitted when a neighbor's statement of "no sickness" in a family could be corroborated without a personal call. Calls were not made at quarantined homes, but all available data were obtained from the neighbors and later checked by the physician who attended the patient. In the town of Stanford, where the inquiry was started, only those families were visited in which it was known that sickness had occurred during the year 1912. A list of these families was secured from the one resident physician, the town and school authorities, and from the churches. Of the methods used the house-to-house canvass is probably the surest and most effective. The method used in the towns of Milan and Clinton is, however, fairly comprehensive, as any sickness of which neighbors would not know in a rural section would probably be of such a nature (venereal diseases, etc.) that the family itself would not report it. Approximately 97 percent of the population was covered in the Fourth Ward of Poughkeepsie, 93.3 percent in Rhinebeck town, and 96.5 percent in Milan and Clinton combined. The total population in these communities, including the Fourth Ward of Poughkeepsie, is about 11,803. Aside from Stanford, with a population of 1,520, where the inquiry was limited to a twelve-months period, and where all the families in which sickness was reported were visited, 2,280 families, 9,853 persons, 96 percent of the total population (10,283), were covered.

"Sickness," for our purposes, has been limited to that which was so serious that it either necessitated or should have necessitated the patient's going to bed or securing medical aid. A slight ailment, such as indigestion, headache, or a light cold, was not taken into account. The international classification was used.

SICKNESS RECORDED.

One thousand six hundred cases of sickness are recorded as having occurred during the sixteen-months period covered by this inquiry. Of these 49 percent were communicable, 42 percent were general medical and surgical cases, and 9 percent were obstetrical. Of the 1,600 patients 19 percent were men, 38 percent were women, and 43 percent were children; 487 cases occurred in the Fourth Ward of Poughkeepsie, 774 in Rhinebeck town, 272 in Milan and Clinton, and 67 in Stanford.

It is not contended that these figures represent the total amount of sickness which occurred within the districts covered during the period named. The investigation, covering, as it did, a period of sixteen months, was begun at the expiration of that period and continued for from three to four months. The population of the territory studied was to a considerable extent shifting. There were a number of families who moved out of a district before they were reached by the investigator and whose records do not appear in the investigator's figures. To some extent their

places were taken by others who moved into the district during the same period. Among the poorer of the population, especially, it often occurred that immediately after a death the family would move out of the house, and in many cases out of the district. In a number of cases a person dying was the last of the family, and the investigator obtained no record either of the sickness or of the death. Also in this as in every community, there was a considerable floating population, casual laborers, and the like, and the records of these it is almost impossible to secure. The number of officially recorded deaths of which record was not obtained by the house-to-house canvass is 54 in the Fourth Ward of Poughkeepsie, 49 in Rhinebeck town, 17 in Milan, and 25 in Clinton. Likewise, the number of officially recorded births not appearing in the confinement cases record of the investigator is 76 in the Fourth Ward of Poughkeepsie, 17 in Rhinebeck town, 6 in Milan, and 9 in Clinton. If these deaths and births were added to the number of cases of sickness of which data were obtained, it would increase the number of cases of sickness 26½ percent in the Fourth Ward of Poughkeepsie, 8 percent in Rhinebeck town, and 21 percent in Milan and Clinton, a total of 16½ percent for the districts covered. The case rate of sickness per 1,000 population in 1912, based on the investigator's figures, would be 80 per 1,000 in the Fourth Ward of Poughkeepsie, 161 per 1,000 in Rhinebeck town, and 63.3 per 1,000 in Milan and Clinton. Or, with the additional data of officially recorded deaths and births, the figures would be 104, 184, and 92 per 1,000, respectively. It will be understood that the case rates per 1,000 population for the respective communities are of value only for the sake of comparison between the separate communities, since they cannot be said to represent the total amount of sickness which occurred.

TIME LOST DUE TO ACUTE ILLNESS.

Among the 1,600 cases of sickness, excluding 5 suffering from infantile paralysis, 15 errors in refraction, 126 confinements, and 15 accidents of pregnancy, there were 987 cases of acute illness, 64 percent of the total number. Among these 987 there was a total of 41,244 days lost on account of illness; 14,375 days of sickness, 35 percent of the total number of days lost, occurred among children from 1 to 6 years; 30 percent of the total number of days lost, or 12,597 in all, occurred among children of school age, from 7 to 14 years.

The loss of 4,125 school days by the 102 children of school age who contracted whooping-cough, of 917 school days by the 74 suffering from measles, of 365 school days by the 16 who had scarlet fever, and of 220 days by 6 typhoid patients, makes a combined total loss for these four contagious and preventable diseases of 5,627 school days, or nearly 29 years of schooling. If the amount of contagious disease among school children were the same for the region not canvassed as for the portion canvassed, there would have been a loss of schooling in the county from these four diseases of 51,150 school days, or about 262 school years.

During the productive period of life, ages 15 to 54, the figures show a loss of 4,983 days by 122 men, an average in each case of 40 days' sickness. For the same age period 186 women were ill 4,838 days, an average of 20 days. This lower average of women as compared with men, a deviation from former experience, is to be explained by the fact that confinement cases are not included. There were 8,001 days lost, or nearly 20 percent of the total, by men and women combined during the ages of 15 to 54. These figures omit 452 cases of chronic illness, 31½ percent, excluded because of the difficulty of securing the facts in chronic cases. Certainly they would add a large loss to that already noted.

CARE SECURED.

Seventy-six percent of the patients recorded secured medical care; 24 percent did not; 66 percent received medical care in their homes, 6 percent in hospitals, and 4 percent both at home and in hospitals; 90 percent remained in their homes during their entire sickness. Of these, 2 percent secured a resident trained nurse, 4 percent secured a visiting trained nurse (only 6 percent in all having the benefit of either resident or trained nursing skill), 5 percent were cared for by a resident untrained nurse, and 12 persons, less than 1 percent, by a visiting untrained nurse. In 2 percent of the homes resident domestic help was secured; in 59 percent some member of the family did whatever nursing was done. The 24 percent previously referred to (26½ percent of the at-home cases) secured no medical care, and of course no nursing care or domestic service of any kind; 42 percent of the trained nursing service secured was resident and 58 percent visiting. Of the untrained service (not including family nursing), 72 percent was resident and 28 percent visiting; 22 percent of the resident service was trained and 78 percent untrained, and of the visiting service 56 percent was untrained and 44 percent trained.

COST OF HOSPITAL AND HOME CARE.

One hundred and fifty-nine cases, or 10 percent of the total number, were treated in hospitals; 99 of these received hospital care only, 60 both home

and hospital care, at a total cost to the patients of about $8,300, of which $4,262 was paid the physicians and $4,035 to the hospitals; 75 percent of the hospital patients paid for their care and 25 percent did not; 73 percent of the patients who remained in their homes paid for medical care to a total amount of over $17,873, an average of $16.90 per patient, a little less than $13,000 of this amount going to the physicians. In 26 cases an average of $104 was paid to the resident trained nurses, in 59 cases an average of $28.50 was paid to the untrained attendants, and in 19 cases an average of $13.43 was paid to domestic helpers.

ADEQUACY OF CARE.

Up to this point we have been dealing with results which involve the recording and compilation of facts. In proposing now to deal with the question of the adequacy or inadequacy of care, we realize there is much room for dispute as to what constitutes adequate care. By "adequate care" is meant that care which results in the patient's recovery when recovery can be expected, and which is of such a character that neither the patient nor the community incurs avoidable risks. Let it be understood that our judgment in this respect is presented only as a judgment, but as one having been made after careful consideration of a great variety of facts touching on all phases of the patients' surroundings and treatment. As stated in the earlier part of this paper, the physician was consulted in each case, the nurse, if there was one in attendance, and also the family. In many cases the data were referred to specialists and their advice secured. It was sought to maintain uniform standards of judgment throughout the whole number of cases considered. Our conclusions are given not as final, but as subject to all the limitations inherent in the methods used.

Of the 1,441 patients who remained in their homes (90 percent of the total number), only 55 percent were cared for adequately, 45 percent receiving inadequate care; 80 percent of the hospital patients were cared for adequately, and 20 percent inadequately, the latter chiefly because of the lack of social service and follow-up work to connect the hospital with the home. In many of these cases the patients returned to homes unprepared for them, so that proper convalescence was impossible. Combining home and hospital care, 42½ percent were cared for inadequately, and 57½ percent adequately.

For the purpose of this study the patients were divided into three economic classes—in one division, those who were able to pay for any necessary service; in another, those able to pay ordinary charges, such as physicians' fees, practical nursing, and ward service in hospitals, etc., but unable to stand a prolonged drain on their income; in the third class, those unable to pay for care of any kind; 81 percent of the patients who could pay for any desired service were cared for adequately, and 19 percent inadequately. Of the patients who could meet ordinary expenses, but could not stand an unexpected or prolonged drain on their incomes, 50 percent were cared for adequately, and 50 percent inadequately. Of those unable to pay, 32 percent were cared for adequately, and 68 percent inadequately. Of the total number of cases inadequately cared for, but 21.3 percent were unable to pay for any care, 14.4 percent could have paid for any necessary service, while the remaining 64.3 percent were able to pay for any ordinary charges, though unable to stand a prolonged drain on their incomes. A consideration of these facts will make it obvious that, while those unable to pay were at a disadvantage as compared with those able to pay, it is still true that there was inadequacy of care without poverty in about 79 percent of those receiving inadequate care.

The time at my disposal will prevent a full analysis or exposition of the reasons for the inadequate care received. A few illustrations will have to suffice. In 30 percent of the measles cases no medical attention was received; no medical care was received in 47 percent of the cases of chickenpox, 35 percent of the cases of mumps, 68 percent of the diseases of the eye and errors in refraction, and in varying percentages in other diseases; 76 cases of measles were not quarantined, and no physicians were present in 22 cases; 5 cases of scarlet fever out of 28 were in quarantine. The records show a varying percentage of the same lack of quarantine in the other contagious diseases. Crowded and unsanitary housing conditions contributed in 23 percent (156) of the cases of inadequate care in the home; ignorance and low grade mentality in another 7 percent (47) of the cases treated at home.

The character of the medical service available in one rather isolated section is shown in the following story:

When George L., 7 years old, first complained of being ill, his mother telephoned to a physician who lived about one mile distant, asking him to call immediately. The physician asked the mother to describe the child's symptoms, which she did to the best of her ability. The doctor then said the child was suffering from indigestion, and told her what to do. She followed the instructons, but the child became worse. Mrs. L. telephoned twice more, asking the doctor to call, and each time was told that the child was suffering from indigestion and that medical attention was not necessary. At the end of a week George was very much worse, and the family decided to consult a different physician. This doctor diagnosed the case immediately as

pneumonia. George recovered, though he was critically ill for three weeks, during which time his mother and father, who stayed home from work most of the time, did the nursing and housework.

A failure to realize the danger of infection to which the patient's family is subject is characteristic throughout the rural sections in which this inquiry was made:

The physician who attented 7-year-old Hazel in March, 1912, for measles said that at that time she was in incipient stage of tuberculosis. He did not see her again, however, until May, 1913, when he thought she had improved under the outdoor treatment which she had been taking under the supervision of her mother. The family could not afford a special diet for Hazel; the home is crowded (seven people living in eight small rooms), and Hazel sleeps with two of the other children. The mother has neither the time nor intelligence to "supervise" treatment of any kind. Two children in the family were still-born, a 24-year-old boy has "chronic asthma," and in 1897 a 5-year-old boy died from "quick consumption" after a three-weeks' sickness.

The disastrous effects resulting from inefficient medical care and the lack of skilled nursing are shown in the following story:

Mr. K. was taken sick in June, 1912. The physician who was called in stated that he had been poisoned in some way, but that there was no danger of the rest of the family becoming infected. A married daughter came home to help with the nursing and housework. Mr. K. became worse, and, when the daughter became seriously ill with what appeared to be the same disease, the family called in a different physician. This physician diagnosed both cases as erysipelas. Mr. K.'s 32-year-old son also became infected. The disease was too far advanced when the second physician was called in to do anything for Mr. K., who died. The rest of the family recovered.

Here are instances where the families were without necessary care:

Carl R., a heavy drinker, has suffered for two years with a "chronic bronchitis." His wife is of low grade mentality. Of the six children, three (Ruth, 13 years old; Hazel, 12 years old; and Gertrude, 10 years old) are "backward" in school. Ada, 8 years old, has never gone to school. For six years, ever since she was 2 years old, she has been paralyzed from the waist down. She wiggles about the room on her arms with inconceivable rapidity, dragging her limbs. Theodore, 4 years old, is "sickly," and throughout December, 1912, and January, 1913, was in a jaundiced condition. A 2-year-old baby is subject to spasms. This family lives in four dirty rooms. A small toilet room containing a filthy flush closet opens directly into an unventilated bedroom. No member of the family has received medical attendance, and it was therefore impossible to obtain an accurate diagnosis of their condition.

Amelia F., whose story follows, was found in a prostrate and dazed condition in bed in the home of Emmy G.:

Mr. G. is feeble-minded and a chronic alcoholic. "Emmy" is a low-grade defective, and there are three children at home all under school age. Mr. G. is one of three men with whom Emmy is known to have lived illegally. The family have six filthy rooms. One slightly cleaner than the others is rented to Amelia F., whose stepfather boards her here, as he cannot afford to pay more than $3.00 a week for her care and has been unable to find quarters for her elsewhere. Amelia has been in bed practically continuously for five years, and her present care is characteristic of the care she has received during this entire period. She has had no medical attendance, and therefore no diagnosis has been made of her condition. She is unable to leave her bed, eats practically nothing, is hysterical, in a constant terrified condition, and at the time of the inquiry was too weak to talk. Her stepfather, a farm laborer, comes to see her once a week, at which time he bathes her, cleans up her room, and does some cooking for her. When he asks "Emmy" to cook any particular food for his daughter, she cooks nothing else but that until he comes again, so that any suggestions are practically useless.

Martha, 8 years old, was first diagnosed as having infantile paralysis on September 9, 1912. She had been sick for one week previous to this time, but a doctor had not been called in. For two weeks following, the physician called daily and then twice a week for a short time. From October, 1912, to January, 1913, she was in a hospital, but the physicians there could do nothing for her, and since January, 1913, she has been in her own home. She is unable to use her legs, but is otherwise apparently healthy. Her father, a farm laborer, is an intermittent drinker and shiftless. Her mother was pictured by the attending physician as being in "poor health." She is now in a very nervous condition, and has been treated at various times for nervous prostration. The nine people making up this family—man, wife, six children, and the man's 13-year-old brother—live in five rooms, where there are three beds and one small cot. The house is in a filthy condition, and is practically without ventilation. Martha, her mother, and baby brother sleep in one bed. A 6-year-old boy and his 13-year-old uncle, who works as a farm laborer, sleep in the second bed. Ruth, 10 years old; Marie, 4 years old; and Reginald, 2 years old, sleep in the third bed. The man sleeps on the cot. The mother would have all she could do to care for her home and children if conditions were normal, and she has more than she can do as things are. Martha, who was in the second grade when she left school, can neither read nor write, and no attempt is being made to teach her in any way. She sits in a child's express wagon from early morning until time to be put in her third of the bed at night.

When Sam K. is drunk, he beats up his "woman" (Mary O.) and six children impartially. The family lives in a filthy three-room ramshackle building. One room is on the ground floor, and the two small adjoining bedrooms on the second floor are accessible only by rickety steps on the outside of the shack. Mary O. is not normal mentally. She last heard of her legal husband when he was in jail, where he had been put for beating her when he was intoxicated. She "thinks" she had two children by Mr. O., but is not sure, and, if she did, they are probably with Mr. O.'s people. She hadn't "thought of them" for some time, so could not recall their ages. She has no idea of her own age or of the children's who are with her. (It was learned incidentally that Mary O. had once been in a state asylum for the insane.)

The following two illustrations show the dire effects of lack of social service organization to "follow-up" the discharged patients:

Annie M. was in the Hudson River State Hospital suffering from "dementia precox" for six months. At the

end of that time she was dismissed and was apparently normal mentally for five months. From March, 1912, until some time in Lent, 1913, she was again mentally deranged, but her family refused to send her back to the asylum. She succeeded several times in getting away from her home, improperly clad. The home care throughout was most inadequate. Her father is a heavy drinker. A 20-year-old sister, described by the neighbors as "not bright," is known to be out late at night, to keep "fast" company, and is supposedly immoral. Annie returned from the hospital to this environment, and no attempt has been made to supervise her or keep her under observation in any way. Neighbors say she is with her sister on all possible occasions.

George W. is a patient in the Hudson River Asylum, in which his sister died. His wife, 41 years old, does day work to support four children. A fifth child, now 18 years old, has been in the Rome State Custodial Asylum for twelve years. A 16-year-old boy, apparently normal, works as a farm hand, earning $10 a month and his board. A 14-year-old boy is also apparently normal, and on Saturdays works on a dairy farm, so that he can contribute $1 a week to the family income. Edna, 12 years old, is unmanageable at home. She refuses to attend school and stays out late at night, and her mother suspects that she has had immoral relations with some of the boys with whom she associates frequently. Mrs. W. has tried having the girl stay with a family in the village, where she was supposed to help with the housework after school hours, but it was impossible for this family to do anything with her or to control her actions in any way. Mr. W.'s sister was a patient in the Hudson River State Asylum at the time of her death.

No attempt will be made in this paper to map out a program for the correction of such evils as have been disclosed. Our present purpose is to give you the findings of this study for what they are worth, with the thought that other communities may be encouraged to study their own facilities and results, and gain much more than we have been able in this first effort.

SUMMARY.

It was found that 49 percent of the sickness reported was communicable; that 41,244 days were lost on account of sickness by 987 persons, an average of 42 days each; 35 percent of this was among children from 1 to 6 years of age and 30 percent among children of school age, 7 to 14; 37 percent of this was on account of four contagious diseases; 20 percent of the total number of days lost on account of sickness was during the economically productive period of life, from 15 to 54. This 20 percent, in our judgment, is small in this community because of the lack of general industrial development. The figures of our study show, also, that 24 percent of the total number of persons sick did not receive medical care; 2 percent of those who remained at home (90 percent of the total number) were cared for by a trained nurse in their homes; 4 percent received the care of a visiting trained nurse, making 6 percent in all who had the benefit of trained nursing service; 59 percent of the nursing that was done was by members of the family. Our study of the case histories—and by this we mean to express opinions, not finalities—shows that 45 percent of the cases treated in their homes received inadequate care, that 20 percent of those receiving hospital care were treated inadequately, and that, while the economic condition of the sick is reflected in the inadequacy, it cannot be explained by poverty alone, since nearly 79 percent of those receiving inadequate care were above the poverty line.

A study of individual cases of sickness discovered shows many shocking instances of neglect, of unnecessary and indefensible suffering and misery. The health work throughout Dutchess county is unorganized. Contagious diseases have spread in the rural districts, with little effort to check the infection. There is practically no connection between the hospital and the home. There is no hospital provision made for the care of contagious and communicable cases other than the tuberculous; none for the care of early psychopathic cases or of alcoholics, and until recently there had been no separate provision for the care of children. No adequate provision is made for the care of feeble-minded and epileptic.

The medical inspection of school children is most inefficient, and the after-care which such inspection should necessarily involve is practically never attended to—at least not in the rural sections. Rhinebeck town is exceptional in this respect, and, although the school nursing has been intermittent until this last year, the importance of the work is recognized and continuous effort is being made to meet the problem presented.

Efficient medical attendance, such as is necessarily involved in any plan for providing adequate care for the sick, is not always available. Trained nurses are secured from the various centers in which they are registered—Poughkeepsie, Brooklyn, New York, Kingston, and Albany—but no attempt has been made in the county to organize the untrained service, nor to develop systematic means of locating the uncared for sick.

The need of "family rehabilitation" work, in connection with the adequate care of the sick and the prevention of disease, becomes especially important when it is considered that the education of the community in health matters cannot progress until in many cases the family has been built up. Likewise neglected disease leads to poverty, dependence, and often to delinquency and crime. In the city of Poughkeepsie the Associated Charities is working to prevent family dependence and deterioration, and the county agency for dependent children, under the super-

vision of the State Charities Aid Association, is showing the need for similar work throughout the county.

The rehabilitation of the family, dependent as it is on the adequate treatment and prevention of disease, is likewise aided or retarded by the success or failure of other social institutions in measuring up to the social needs of the community. The local justices of the peace clearly fail to meet these needs. It seems of the utmost importance, therefore, from this point of view, that more adequate methods be devised by the courts for handling cases involving the welfare of the family. The establishment of a county juvenile court and the organization of an effective county probation system would afford more adequate legal machinery than now exists for dealing with such court cases. A city probation officer has since been appointed in Poughkeepsie, and in July, 1914, one was appointed in the county at large.

Recent legislation promises good results. Following the recommendations of a special public health commission, legislation was enacted which greatly extended the scope and equipment of the state department of health. Among the newer agencies created was the Public Health Council, with broad powers, which include that of establishing a sanitary code for the state outside of New York City. There was created also a system of sanitary supervision by district sanitary supervisors for each of the twenty districts into which the state was divided (cities of the first class were excluded). These supervisors will cooperate with the local health officers and act as the representatives of the state commissioner of health in securing within their districts the enforcement of the provisions of the public health law and the sanitary code. Power was given to the commissioner of health to employ public health nurses and assign them to any district in the state.

This new machinery is in the process of organization, and the sanitary supervisors are about to be appointed. Time must be allowed for the working out of any improved methods.

The importance of the findings of the house-to-house canvass of selected districts of Dutchess county lies in the fact that there is every reason to believe that the amount of inadequately cared for sickness discovered is typical of what may be expected to be true of every similar community throughout the county. Here are normal small city and country communities in normal times—no unusual epidemics, no extraordinary social or industrial conditions—during a period shown by reported deaths, reported cases of contagious disease, and the unanimous testimony of physicians to have been a "light year" for sickness, and yet we find that in these typical communities under favorable conditions, uncared for sickness and neglected subnormal lives challenge us from our self-complacency to ask, Why?

Some may conclude that Dutchess county is one without resources, and, therefore, unable to meet its own problem for lack of money. On the contrary, it is a county of more than average wealth. It is the seat of Vassar College, one of the most advanced institutions of learning for the education of women. Among its residents are some of the wealthiest families of the state, large endowments are utilized within its borders, the Thomas Thompson Trust and other funds are used for charitable, educational and health purposes. All this points, not to a lack of resources, but to a failure of the people to realize the actual conditions obtaining around them, and to an absence of effective organization by which such conditions may be ascertained and the remedies applied.

Our justification for presenting the findings of a study made in a New York county is that it seems to illustrate what is probably a general condition and not a purely local situation. If we were to hazard a guess, we should say that Dutchess county is above the average in its care of the sick, as it is in wealth and resources.

TABLE I.

Population, Percentage Covered, Total Cases, and Sickness Rate per 1,000 of Population in Selected Districts.[1]

	Fourth ward.	Rhinebeck town.	Milan and Clinton.	Total.
Population	4,580	3,532	2,171	10,283
Total number of families	1,065	855	463	2,383
Number of families not at home	30	57	15	102
Percentage of families covered	97.1	93.3	96.7	95.7
Population covered	4,451	3,306	2,096	9,853
Percentage of population covered	97.1	33.3	96.5	95.9
Total cases of sickness[1]	487	774	272	1,533
Cases of sickness, 1912	355	533	139	1,027
Cases per 1,000 population, 1912[2]	80	161	66.3	104

[1] 67 cases in town of Stanford omitted.

[2] Cases per 1,000 of population indicated only for purposes of comparison between localities, as data do not include all cases of sickness occurring in district covered. See context under "Sickness Recorded."

TABLE II.

Classification of Recorded Sickness by Diseases and Locality.[1]

	Diseases.	Fourth Ward of Poughkeepsie.		Rhinebeck village.		Rhinecliff village.		Rhinebeck town.		Milan.		Clinton.		Stanford.		Total.	
		1912	1913	1912	1913	1912	1913	1912	1913	1912	1913	1912	1913	1912	1913	1912	1913
1	Typhoid fever	6	..	14	3	..	..	1	1	4	..	..	..	..	..	25	4
2	Malaria	13	1	2	..	1	..	1	..	..	1	..	..	..	..	17	2
3	Measles	5	3	3	1	7	44	5	23	18	33	..	14	3	..	41	118
3a	German measles	..	9	..	..	..	7	..	..	..	1	..	..	..	..	..	17
4	Scarlet fever	18	3	1	..	..	1	1	4	..	..	..	..	..	..	20	8
5	Whooping-cough	10	2	78	2	9	2	57	19	..	39	7	4	..	..	161	68
6	Diphtheria	1	2	..	..	..	2	..	..	..	..	..	..	..	..	1	4
7	Influenza (la grippe)	12	18	..	18	1	..	4	2	1	..	2	2	1	..	21	40
8	Erysipelas	1	..	..	..	..	..	2	3	..	..	..	..	1	..	4	3
9	Chickenpox	9	7	..	3	..	..	3	10	5	1	2	2	..	..	19	23
10	Mumps	4	16	1	3	..	..	..	5	..	3	..	2	..	..	5	29
11	Infantile paralysis	1	..	..	..	2	..	..	..	2	..	..	..	..	..	5	..
12	Tuberculosis (pulmonary)	10	..	5	..	1	..	2	..	3	..	2	..	1	..	24	..
	Tuberculosis (other forms)	3	..	1	1	..	..	..	..	..	..	..	..	..	..	4	1
13	Cancer and other malignant tumors	11	..	..	..	1	..	4	..	..	..	6	..	1	..	23	..
14	Syphilis and gonorrhea	..	..	..	..	..	..	1	..	..	..	..	..	..	..	1	..
15	Acute and chronic rheumatism	9	4	16	3	2	2	7	..	6	1	2	1	2	..	44	11
16	Diabetes	4	1	1	..	..	..	2	..	..	..	..	..	..	..	7	1
17	Alcoholism	10	..	8	..	5	..	3	..	3	..	3	..	4	..	36	..
18	Anemia, pernicious and secondary	7	3	1	1	5	..	..	1	2	..	1	..	..	..	16	5
19	Meningitis, simple and cerebro-spinal	..	..	1	..	..	..	1	..	..	1	..	..	1	..	3	1
20	Cerebral hemorrhage—apoplexy	3	..	3	3	..	..	..	2	2	..	..	1	2	..	10	6
21	Organic nervous diseases	5	3	4	3	1	2	2	..	..	..	2	1	2	..	16	9
22	Paralysis	5	..	..	..	2	..	1	..	..	..	..	..	..	..	8	..
23	Epilepsy	1	..	1	..	1	..	1	..	..	..	1	..	..	..	5	..
24	Insanity	5	..	4	..	1	..	1	..	..	..	..	..	3	..	14	..
25	Other functional nervous diseases[2]	9	2	4	..	4	1	3	1	1	..	1	1	1	..	23	5
26	Diseases of the eye	8	..	4	..	2	1	12	..	1	..	4	..	..	..	31	1
27	Diseases of the ear	3	2	1	6	..	..	1	..	..	..	2	..	..	..	9	8
28	Diseases of the heart	9	..	4	..	2	..	5	..	..	..	1	1	2	..	23	1
29	Diseases of the arteries	4	..	..	..	..	..	1	..	..	..	1	..	..	..	6	..
30	Diseases of veins, lymphatic system, etc.	1	..	1	2	1	..	1	..	..	..	..	..	..	..	4	2
31	Bronchitis, acute and chronic	8	3	3	5	2	..	5	1	2	..	..	..	..	..	20	9
32	Pneumonia	7	4	10	1	2	2	2	1	2	2	1	1	5	..	29	11
33	Broncho-pneumonia	..	2	1	1	..	1	..	..	..	1	..	..	..	..	1	5
34	Asthma, pleurisy, diseases of nose, larynx, and pharynx	13	9	14	1	1	..	4	..	3	..	..	..	2	..	37	10
35	Tonsils and adenoids	12	7	13	6	2	..	5	1	1	..	4	4	..	..	37	18
36	Diseases of the stomach	8	6	8	1	2	..	2	..	3	..	1	2	4	..	28	9
37	Diarrhea and enteritis	2	..	1	2	..	..	..	..	..	..	..	..	..	..	3	2
38	Hernia, intestinal obstructions	3	..	2	..	1	..	1	..	..	..	..	..	..	..	7	..
39	Appendicitis	14	..	3	..	2	..	5	..	..	..	..	..	1	..	25	..
40	Other diseases of digestive system	..	..	1	2	..	..	..	..	..	1	..	..	..	..	1	3
41	Diseases of the liver	..	1	..	..	..	..	..	..	..	..	..	..	1	..	1	1
42	Nephritis, acute and chronic	6	..	4	..	1	..	3	..	3	..	..	..	1	..	18	..
43	Diseases of g. u. system, male	..	..	5	1	..	..	2	..	1	..	2	..	3	..	13	1
44	Diseases of g. u. system, female	18	2	8	2	1	..	1	..	..	..	2	..	5	..	35	4
45	Confinements	32	14	16	8	7	1	12	9	5	4	5	5	8	..	85	41
46	Puerperal septicemia, accidents of pregnancy and of labor	4	1	4	2	..	..	1	1	..	..	..	1	1	..	10	5
47	Diseases of the skin	4	1	3	1	..	1	2	..	..	..	2	..	..	..	11	3
48	Malformation	4	..	2	..	..	..	1	..	1	..	2	..	..	..	10	..
49	Diseases of early infancy	1	..	..	..	..	..	..	..	..	..	..	2	..	..	1	2
50	Senility	8	..	14	..	4	..	6	..	4	..	..	..	9	..	45	..
51	Diseases of bone, joints, etc	1	1	..	..	..	..	..	..	..	..	..	..	1	..	2	1
52	Fractures and other accidents	10	1	5	2	2	..	4	2	1	..	1	1	2	..	25	6
53	All other diseases	13	4	3	..	..	2	2	2	1	..	5	..	..	..	24	8
	Totals	355	132	278	84	75	69	180	88	77	88	62	45	67	..	1094	506

TABLE III.

Summary of Medical Care Secured.

Medical care		1,217 (76 percent)
At home	1,058	
In hospitals	101	
At home and in hospitals	58	
No medical care (remained at home)		383 (24 percent)
		1,600

[1]Data for 1913 are for first four months only.

[2]Defectives—treated separately.

TABLE IV.

Number of Cases of Chronic and Acute Illness, and Number of Days Lost and Average Duration Due to Acute Illness, by Age Periods.[1]

Age.	No. cases.	Chronic.	Acute.	Days lost due to acute illness.[1]	Average days' duration acute illness.
1-6	293	24	269	14,375	53.4
7-14	349	44	305	12,597	41.3
15-19—Men	33	10	23	1,031	44.8
Women	22	7	15	366	24.4
20-29—Men	57	14	43	1,249	29
Women	68	19	49	1,444	29.4
30-39—Men	45	23	22	707	32.1
Women	89	31	58	1,592	27.4
40-54—Men	60	26	34	1,996	58.7
Women	112	48	64	1,434	22.4
55 plus—Men	120	79	41	1,198	29
Women	191	127	64	3,253	50.8
Total	1,439[2]	452	987	41,244	

TABLE V.

Summary of Nursing and Domestic Service Secured.

Remained at home		1,441 (90 percent)
Secured no care	383	(.265 percent)
Secured resident trained nursing	31	(.022 percent)
Secured visiting trained nursing	53	(.037 percent)
Secured resident untrained nursing	77	(.053 percent)
Secured visiting untrained nursing	12	(.008 percent)
Secured resident domestic help	32	(.022 percent)
Secured visiting domestic help	1	(.001 percent)
Secured family nursing	852	(.591 percent)
	1,441	

TABLE VI.

Summary of Hospital Care Secured.

	Fourth Ward.	Rhinebeck town.	Milan, Stanford, Clinton.	Total.
Number of men patients	24	22	6	52
Number of women patients	39	46	10	95
Number of children patients	4	12	3	19—166
Medical cases	27	30	5	62
Surgical cases	36	31	12	79
Obstetrical cases	1	12	1	14
Psychopathic cases	3	7	1	11—166

TABLE VII.

Adequacy of Care by Total Number of Patients.

	Home care.	Hospital care.	Total.
Total number cases	1,441	159	1,600
Number patients who received adequate care	793	127	920
Number patients who received inadequate care	648	32	680
Percent adequate care	55 percent	80 percent	57½ percent
Percent inadequate care	45 percent	20 percent	42½ percent

TABLE VIII.

Adequacy of Care by Locality.

	Fourth Ward.	Rhinebeck town.	Stanford, Milan, Clinton.	Total.
Total number cases	487	774	339	1,600
Total number adequately cared for	282	481	157	920
Total number inadequately cared for	205	293	182	680
Percent adequate care	58 percent	62 percent	46 percent	57½ percent
Percent inadequate care	42 percent	38 percent	54 percent	42½ percent

[1]Number of days lost due to chronic illness not tabulated.

[2]Does not include 5 patients suffering from infantile paralysis, 126 confinements, 15 accidents of pregnancy, and 15 eyes—errors in refraction.

GROUPING OF MEDICAL MEN FOR OFFICE AND HOSPITAL PRACTICE.

The Great Middle Class Cannot Pay Consultation Fees, and Therefore Cooperation in Diagnosis and Treatment Is Logical Result—A Successful Illustration.

By P. E. TRUESDALE, M. D., and R. W. FRENCH, M. D., Fall River, Mass.

THOROUGHNESS in methods of diagnosis and treatment is the watchword of today. To attain this, the grouping of specialists offers an example of the forecast of the development of medical practice. Cooperation of medical men, placed in convenient, harmonious, and reciprocal relations, offers the only logical way to make the vast and complicated range of medical knowledge fully serviceable to the individual patient. In this way only can adequate service be rendered without waste and for moderate fees, such as the great middle class can reasonably afford to pay.

Nowadays patients may be divided into three classes. First, the charity patients, who are sent to the general hospital, and there receive, with little or no cost, all the laboratory work that is necessary, together with the advice of all the specialists that may be desired. Second, the well-to-do patients, who receive expert service, but who can afford to pay consultation fees to the various specialists for their work. Third, the largest class of patients, who do not wish to accept charity, but who cannot afford to pay consultation fees to numerous specialists. These last patients, in general, are today receiving the least satisfactory treatment.

The plan of grouping physicians as it is being worked out in Fall River, Massachusetts, is done chiefly to give patients of moderate means access to specialists in the various branches of medicine and surgery, and to keep the charges well within their financial ability. A centrally located building, incorporated under the name of the Truesdale Clinic, and designed for the purpose, is now established for the cooperative study of patients. The first two floors are devoted to offices and examining rooms, with waiting rooms, and a main office at the entrance, where information may be had and where clerical work is done. On the third floor is the x-ray department, a chemical and bacteriological laboratory, an operating room for minor cases, a sterilizing room, two recovery rooms, and two offices.

The secretary's office serves as a record room, where all data relating to patients is kept on file. Here, too, is kept a card index system of the diagnoses recorded on the history cards, which facilitates the grouping of diseases for ready reference. This department has also a system of following up hospital patients, to acquire definite knowledge of end results of treatment.

On the second floor is the library, of which the secretary has charge. It is her duty, as librarian, to keep members of the clinic informed on all recent medical literature which concerns the individual specialist. She maintains a filing system for all reprints received and a reference system to current medical and surgical publications.

Most of the patients come to the office building and ask to see a particular physician. If the case is within his province, he treats the patient, who then leaves without seeing anyone else. If the case is one which can be more satisfactorily cared for by another physician, the patient is then transferred. Many of the cases are simple and quickly disposed of; but, on the other hand, there is a relatively large number which demand an exhaustive investigation in order that a safe degree of accuracy in diagnosis may be attained before treatment is undertaken. In these cases the patient has x-ray examination, laboratory tests, and consultations which may be deemed essential until a diagnosis is established.

The business management of a clinic of this character is not a happy part, but it is nevertheless a very essential one. It would simplify matters if each doctor were working on a salary, paid by the corporation. But this arrangement has two serious objections: first, that the salaries would have to be so large that it would not be possible to employ the required number of specialists; and second, that each physician in the building already has a practice of his own, which he is loath to release. Therefore, it seemed best that each man should keep his own accounts separately and make his own collections. When a physician in the clinic sends his patient to one or more specialists for consultations, etc., the fee is adjusted by the physician who starts the case, since he has a more intimate knowledge of the patient. The bill is itemized, so that the patient knows how much he is paying for each examination. It is then sent by the clinic, and, when paid, the various amounts are credited to the physicians to whom they are due. This is more satisfactory to the patient than receiving several different bills, and generally at different times.

Rents in the building vary according to position and size of the rooms. The income from this source is designed to pay for taxes, light, heat, maintenance, supplies, office attendants, and interest on the investment.

The clinic is associated with two hospitals intended to cover the requirements of all classes of patients: St. Ann's Hospital, a religious institution, located in a busy section of the city, which provides wards and private rooms; and the Highland Hospital, private, designed as a modern hospital and located on an ideal site remote from the built-up section of the city.

The physicians and surgeons in the clinic are on the staffs of both hospitals, and patients needing hospital treatment are sent to one or the other of these institutions. All evidence bearing on the case accompanies the patient to the hospital.

Our clinic is young, and our working plan is not yet ideal. Nevertheless, it is so obviously logical, and better than the isolated method of office practice, that the plan can no longer be considered an experiment.

The hub of our work involves a heart interest on the part of every man connected with it for the success of its functions and the achievement of higher standards.

NEW ERA FOR THE GENERAL MEMORIAL HOSPITAL.

Fine Endowment and Reorganization Will Permit Splendid Institution to Broaden Its Work in Cancer Research, Prevention, and Possible Cure.

By MRS. ANNA MEREDITH LAWSON, Emeritus Superintendent.

ABOUT the year 1884 two women, deeply interested in the subject of cancer, conceived the idea of building a hospital to be devoted to cancer, its treatment and study. These two pioneers in this work, Mrs. John Jacob Astor and her cousin, Mrs. George B. Cullun, by their generous gifts made possible the building of the Cancer Hospital. Many influential names were added to this roll of honor, and on December 7, 1887, the doors of the New York Cancer Hospital were thrown open to the sufferers from the dread disease, and it became a factor in the cause for which these noble women had striven.

Looking backward over the old records, one finds such names as James B. Hunter, Brayton Ball, William T. Bull, George F. Shrady, Francis P. Kinnicutt, and Frank Hartley of the medical staff. All gone to reap the reward of devotion to their fellow-men. We find also Clemens Cleveland and Henry C. Coe, who are still ready with their skill.

The first president, Mr. John R. Parsons, is at the helm, actively engaged in furthering the good work. The prejudice against the word cancer, however, was so great that in 1899 it was deemed best to change the title of the hospital so that by special legislative act it became the "General Memorial Hospital for the Treatment of Cancer and Allied Diseases." The scope of work was largely, almost entirely, surgical, but, because of the pressing need of funds, diseases other than malignant were accepted in the private rooms and certain wards if susceptible of surgical interference.

Quite recently Dr. James Douglas has endowed the institution most generously, with, however, the distinct understanding that the scope of work shall be entirely along the lines of cancer research and investigation, and that it be affiliated with Cornell University Medical Department. The Dean of Cornell will in the future be a member of the board of managers of the hospital and a trustee of the fund. The active surgical and laboratory workers will also be connected with Cornell. This has given a new impetus to the important work, and has brought in its train many changes—changes on the boards of both managers and medical staffs. A new medical board was appointed, and by its affiliation with Cornell the doors to the best methods should stand wide open. At least it has at last a means to an end, for, without the generous aid of those who have, no such enterprise can exist.

The General Memorial Hospital has now a large quantity of radium, and by January will have much more. Its roentgen-ray plant is second to none, and it takes a sufficiently open-minded attitude toward the cures, or would-be cures. Surely some results will crown these efforts, and no matter whence will come that long-sought-for conqueror, credit will be given where honor and credit are due. The watch words are recognition and prevention. These make up the strength of the effort being made. Good luck, then, to the General Memorial and its workers; may its old aims along new lines extend, and its beneficence be felt throughout this and the ages to come. It is a crusade—a crusade of individuals for individuals. It is work for mankind and for womankind.

Think of the splendid aids—surgery, radium, roentgen rays,, serums, science in its many forms, and the intelligence of the times in which we live, and which is the birthright of every man, woman, and child.

This great work owes a quintuple duty—to the surgeon who gives his skill, to the scientist who

gives his time, to the philanthropist who gives of his abundance, to our neighbors, to ourselves.

One of the most generous donors to the cause of cancer always alludes to it as the dark secret. Will it remain dark, and for how long? The book of Genesis tells us, "He said, let there be light, and there was light." It is for us to use the means God has given us, and, fortified by faith and His help, to go forth to fill by every known means the "lamp of science," that it may light the pathway to a recognized and established method of cancer control.

Cancer! cancer! We have all been brought face to face with the awful dread the mere word calls forth. In whispers we are told that this friend or that acquaintance "died of cancer." In our own households its terrible presence may have been felt, and yet the search goes on for the cure that is not yet. Surgical effort, science, all have striven, are still striving, to throttle this grim destroyer, who is almost seen to smile and reach out for the next. And whom? Shall it be a sorrowful regret for the friend who has passed, or shall it be one of our own—some one nearer and dearer than our own life?

The General Memorial Hospital, I think, has struck the keynotes—investigation, research. It is sending out its force to teach the world what to do; it is making the effort to impress the men who are educating and bestowing degrees on future savants to recognize cancer when they see it. Better the doubt than the error, and, if embryo physicians and surgeons were made to go through the wards of malignant cases before their degrees were recommended, it would be admirable. Of course it is an insidious disease, but a broader medical efficiency would aid the cause, and this is one of the many things Cornell proposes to do.

For laymen and laywomen another course is marked—one of example, of making those comprehend the importance of having any unusual symptom, a growth, no matter how small, examined by the best medical man they know, and, if he says cut, then take his advice. Make those with whom you come in daily contact—friends, servants—fully aware of the meaning of this safeguard, and insist that cancer is not a disgrace. It is no respecter of persons or places—palaces and slums are both visited by this most impartial destroyer. Tear away the veil of secrecy, look on it as a dispensation of an all-wise Providence, and treat it intelligently.

It is a difficult and expensive problem to run well a hospital for cancer patients. The labor question is a burning one. Only those really interested or highly paid will give their services. The community at large has always regarded the disease with horror, as if in some way it was a personal disgrace. To level this prejudice is a step in the line of progress, and I shall hope to see the open door bring about results.

An American Hospital in Europe.

The Boston *Medical and Surgical Journal* contains an interesting report of the American hospital relief ship Red Cross that reached Rotterdam, Holland, October 6. The expedition consisted of six surgeons and twenty-five nurses, who left immediately by train for their respective destinations in Austria and Germany. One unit is assigned to each country. The two units recently landed in France have been stationed at Mont-de-Marsan. Various churches in the United States contributed on Peace Sunday, October 4, $5,661. The total New York fund, inclusive, makes a total of $225,187, and on October 9 the total of the American Ambulance Hospital (Neuilly) fund reached $69,931. Considerable funds have also been contributed to the Belgian relief fund and to the Prince of Wales national relief. The American Ambulance Hospital at Neuilly (Paris) is apparently winning golden opinions for efficiency. Sir Frederick Treves, Bart., sergeant-surgeon to King George, describes his impressions of the American Hospital at the Lycee Pasteur at Neuilly as being an institution of which the Americans have reason to be proud, as it is the best of its type in Paris. The number of beds is 300; there were 370 patients, of whom 162 were British. The staff consists of fifteen doctors, seventy-five fully trained nurses, and others, making a total of 180. The great difficulty in the medical aspect of the war is the question of transport. More ambulance trains are being provided, but they will not be immune from the risk of being delayed at sidings, the great need of the campaign being motor ambulances. The American Hospital has twenty, and in this fleet of cars rests largely the secret of its success. Another observer in a letter from Paris describes the field work of the American ambulance corps with a squadron of automobile ambulances attached to the hospital, ten of which were presented by the manufacturers and ten purchased. Their chassis have been covered with khaki hoods and fitted to carry two wounded men and attendants. On their runs they are accompanied by automobiles with medical supplies, tires, and gasoline. The ambulances scout at the rear of the battle line, and carry back those whom the field hospitals cannot handle.

Equally favorable opinions have been expressed by Sir Frederick Treves and others of the efficiency of the American Women's War Relief Hospital at Torquay, England, where a unit of the Massachusetts Red Cross has been stationed.

A national leprosarium to cost $500,000 is provided for in a bill introduced in the House of Representatives by Congressman Lewis L. Morgan, of Louisiana. The measure was presented at the request of a large number of persons in Iberville Parish, La., who object to the Louisiana Lepers' Home being located in their midst. The bill also is expected to meet a general demand of the people of Louisiana, who are supporting lepers from many states. It carries out the ideas of Dr. W. C. Rucker, of the United States Public Health Service, now stationed in New Orleans. While no suggestion is made as to the locality of the national institution, arrangements have been made to point out the advantages of establishing it in Louisiana should the bill pass. The objection to the present home is due largely to the facility with which, it is said, the patients obtain their liberty and wander into towns and villages in the vicinity.

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Poverty and Sickness.

On other pages Mr. Stewart Johnson, secretary of the Hospital for Sick Children, Great Ormond street, London, presents to us a most valuable contribution on poverty as one of the ruling causes of sickness among the poor.

We all know that Mr. Johnson is correct in his generalization, and we know, too, that very much poverty, where sickness has not caused it, is due to want of thrift on the part of the victim, or intemperance, or, as Dr. William A. White, of the Government Hospital for the Insane at Washington, describes it, the "inability to get along in the community." Dr. White thinks that the want of "money sense" is as much a mental abnormality as any other onesided development, such as we sometimes find in geniuses who lack balance—the only difference is that the genius is forgiven because of what he has, while the unfortunate who has no predominating trait to offer as an offset to his lack of "acquisitiveness" find little sympathy.

However, the first step in the cure is the diagnosis, and, since we recognize poverty as one of the leading, even if remote, causes of sickness, we are getting along. One who has the "money sense" can never take away genius from its possessor, but very often he is able to deprive him of its fruits. Perhaps the day will come when the dreams of socialism will have gone so far that society will have discovered some method by which all its members can be directed in their energies so that the world will get the benefit of their most progressive powers, and at the same time so that the individual will be protected along those side lines where he lacks the ability to protect himself.

In the meantime let us spend a little more money in prevention, to save a far greater outlay in a futile attempt to cure without removing the cause.

James Gregory Mumford.

Born December 2, 1863.
Died October 18, 1914.

By the death of James Gregory Mumford, at Clifton Springs, New York, on Sunday, October 18, 1914, the profession of medicine in this country loses a skillful surgeon, an industrious and discriminating student of medical literature, a brilliant and facile writer, and an active worker in the cause of medical progress. Those who were so fortunate as to be numbered among his friends lose, also, the ennobling example of a patient acceptance of grave disability, and an indomitable courage which rose superior to physical infirmities and discovered new and greater opportunities to continue a life devoted to the service of mankind.

Dr. Mumford gave fully of his energy and ability in many fields of medical endeavor. He was trained as a surgeon at the Harvard Medical School and in the Massachusetts General Hospital. He subsequently served on the staff until ill health forced his resignation of the position of visiting surgeon. During this period he was an instructor in the Harvard Medical School, and one of its most stimulating and inspiring teachers. When sickness made necessary a life of lessened physical activity, Dr. Mumford assumed the duties of physician-in-chief to the Clifton Springs Sanatorium, where he found opportunity, among his books and surrounded by his chosen staff of sympathetic friends and helpers, to pursue the great ideals of medicine to which his devotion was ever manifest. More than a year ago Dr. Mumford was one of a small group of men who saw an opportunity to serve the great and growing hospitals of the country by the creation of a journal devoted to their interests. After THE MODERN HOSPITAL became a realization, he contributed more than his share to call attention to potential avenues of progress, especially in sanatorium practice, and his editorials served to awaken dormant consciences and to greatly improve conditions.

It is as a writer, however, that Dr. Mumford's name will most permanently endure. Always a diligent and discriminating reader, he soon de-

veloped a taste for medical literature and for the historical investigation of medical subjects, to which he brought a quickening human appreciation, that infused with life the driest and most prosy of the "medical worthies," in whose writings he took such keen delight.

The felicity of expression and the elegance of diction which his writings show were cultivated by wide reading and painstaking industry. He wrote carefully, correcting and improving his manuscript until it satisfied even his own fastidious taste. Whether it were a text-book for medical students, a more elaborate treatise for professional readers, or one of his delightful essays on medical affairs for the edification and enlightenment of the world at large, his style, like the man himself, was clean, strong, and intolerant of hypocrisy and sham.

ROBERT B. GREENOUGH.

Foreign Hospital Fiction.

Very much is being made in foreign mission circles in this country over the publication in the *Epworth Herald* and some secular journals of the fact that some of the foreign mission hospitals in the Orient are being conducted for miraculously low per-capita costs. One of the cases recently cited is the Wiley General Hospital, of Kutien, China, where, it is asserted, a 75-bed hospital is being operated at a total cost of $4 per day.

Of course, the statement that any hospital anywhere, of any size whatever, is being operated for any such money is nonsense. The writer of this editorial heard a foreign missionary state in public, a year or so ago, that in his China Hospital patients were being cared for at 7½ cents per day. At the end of the address, which was an appeal for money, some questions were asked, and it developed that the 7½ cents bought nothing at all, and that the patients, by taxation of a cent for this and a cent for that, paid for their care (?), and that the bulk of the expense of the hospital was met out of funds of the foreign missionary society which was behind the hospital.

Anyone interested in this subject will do well to read an issue or two of the *China Medical Journal*, published under the auspices of the Medical Missionary Association of China at Shanghai. One is struck at first glance of this ably conducted and well-published scientific journal, with the splendid medical and surgical work that is being done at the antipodes by a fine representation of American, British, European, and native physicians. Some of their research work into the indigenous diseases is as good as that done anywhere, and some of the case histories from their hospital clinics show that thoroughgoing, scientific surgery and medicine are being practiced. That some of their hospitals are being conducted as well as those in newer parts of the world, admits of no doubt when one reads of their results. That their administrators appreciate the latest advances in hospital practice was shown, for instance, when a subscription to THE MODERN HOSPITAL came some months ago with the following specified instructions:

> "Shipments to be made three times a year, four issues at a shipment; to be packed to carry 250 miles across the mountains on mule back."

People who run 75-bed hospitals on $4 per day are not concerning themselves even about THE MODERN HOSPITAL, and nearly every hospital in China subscribes for THE MODERN HOSPITAL, and some of them make better use of it than some other hospitals nearer home.

The boards of foreign missions had better temper the imagination of some of their propagandists, and make them tell us the truth about some of the fine hospital work their institutions are doing, rather than indulge in the fiction they have been giving us about conditions that would be anything but creditable if they were true—which they are not.

Papers on Small Hospitals.

In the January number of THE MODERN HOSPITAL is to begin a series of seven papers on topics of vital interest to small hospitals, by Miss Nettie B. Jordan, superintendent of the Aurora General Hospital, Aurora, Ill.

When THE MODERN HOSPITAL asked Miss Elizabeth Greener to prepare the series of papers that all of us found of such deep interest, it did so with the knowledge that Miss Greener was the superintendent of a hospital that had plenty of money, a rich endowment, that would permit it to develop practices without reference to first cost, without reference to expediency, but wholly in the interest of good hospital service without reference to the expense.

Many hospital workers felt that these papers were limited in their value to them, because financial problems were uppermost in their minds when considering hospital practices and hospital methods, and that they had a far different task from that of Miss Greener, who had no financial problems to worry about. Miss Greener set the pace for splendid efficiency in her series of papers, and they have been of untold value to hospital workers everywhere.

At the end of Miss Greener's papers it was decided that another series of papers was required, a series covering the operations of small hospitals which had to find their funds, and in which the

financial problems were always uppermost. In looking over the small hospitals, the editors decided that the Aurora Hospital, especially under the management of Miss Jordan, would lend itself to what was needed better than almost any other hospital in the country.

The Aurora General Hospital has 50 beds, and has now under construction a new wing that will increase its capacity. Nearly everyone who has attended the American Hospital Association conventions in recent years has come to know Miss Jordan for the breeziness and incisiveness of her discussions of hospital problems. When she went to the Aurora General Hospital a few years ago it was comfortably asleep and apparently enjoying its siesta. It was immediately and violently awakened, and not only the hospital, but its board of trustees, its medical staff, and the public have been wide awake ever since and constantly on the move. Miss Jordan is a most ambitious and active young woman. When she wants a thing in her hospital, she has the knack of getting it, because she first goes out and gets the money. The result is that she has practically what she wants and she has made of her hospital practically what she thinks it ought to be.

Miss Jordan will tell us in her series of papers how she did it all and what the result has been. Since she is a college woman and writes quite as well as she talks, we may expect to enjoy some most valuable, entertaining, and interesting papers. The list of topics follows:

January—"Raising Funds and Financing a Small Hospital."

February—"Business System in the Small Hospital."

March—"Comparative Service in the Community Hospital."

April—"Nurses and Nursing in the Small Hospital."

May—"Standardization of Medical Service in the 'Open Door' Hospital."

June and July—"Planning and Building a Small Hospital" (two papers).

August—"Psychology of Anesthesia."

Mrs. Anna M. Lawson Resigns.

Mrs. Anna M. Lawson, who for twenty-five years was superintendent of the General Memorial Hospital in New York City, has resigned her position, leaving the hospital in October. This closes, temporarily, a hospital career which has been characterized by signal efficiency and success. Mrs. Lawson began her preparation for hospital work by entering the training school for nurses of the New York Hospital, intending from the beginning to fit herself for hospital executive work and not to follow the nursing profession. During this part of her career she gave evidence of a marked inherent quality of executive ability, which found full development later.

Soon after finishing her course in the hospital she was invited to take charge, as superintendent, of the General Memorial Hospital, then known as the Cancer Hospital. During her administration the name was changed, and the service greatly enlarged by becoming a general surgical hospital, taking rank among the leading institutions of the city.

We are glad to learn that it is Mrs. Lawson's intention to continue active work, though not in a residential executive position, of a kind for which her long experience has qualified her.

Only a Dead Mouse.

A few days ago Associated Press dispatches from New Orleans to the daily papers stated that Assistant Surgeon-General Rucker, of the Public Health Service, and his associates, who are engaged in fighting the bubonic plague, had come across a dead mouse in one of the streets, and that microscopic investigation had developed the fact that death had been caused by the plague. Heretofore it has been known that plague was transmitted from the rat, the mongoose, squirrels, and prairie dogs, but this is the first instance discovered of plague in a mouse.

The last official report concerning the plague work of Assistant Surgeon-General Rucker and his force stated that up to date in the New Orleans fight there had been caught 126,966 rats, of which 189 were positive as having the plague. During the last week a huge amount of work was done in New Orleans. More than 100 vessels were inspected and fumigated, 1,097 cars were inspected and passed, 2,158 cars were ratproofed, and 17 cars were disinfected. These cars were destined for 41 states, Louisiana receiving 1,091; Mississippi, 612; Illinois, 451; Texas, 226, and other states smaller numbers.

During the week also 9,542 premises were inspected, 675 of these were disinfected, poisons were placed in 4,500 places, and notices were served on landlords in 3,336 instances. In ratproofing work the service laid 20,074 square feet of concrete and ratproofed 2,146 buildings. The number of rats taken in traps during the week was 7,074.

These figures are cited merely to indicate the magnitude of the work that the Public Health Service has on hand. The plague in New Orleans is a serious menace, although the department was able last week to report that not a single case of

either rat or human plague had been discovered during the week.

It is and has been a difficult matter to catch and destroy rats. If it develops that mice are also to be hosts and distributors of plague fleas, the possibilities are grave indeed. Rats can hide in some of the coarser merchandise, in cars and on ships, but they can also be discovered and driven out. The same methods of procedure would be impossible with mice. The smallness of these rodents permits them to hide in banana bunches, crates of the citrous fruits, in the heads of pineapples, and in almost any merchandise that has to be packed in straw.

If this mouse plague spreads, another very grave danger will follow, viz., that from dogs which are most inviting hosts for fleas of any sort. Assistant Surgeon-General Rucker has already warned the public through THE MODERN HOSPITAL that dogs can easily become hosts for plague fleas. Now, if these plague fleas are to be distributed broadcast by means of mice as well as rats, then the house dog question is to become a very prominent and immediately threatening problem.

Miss Ida Barrett's Election.

Owing to a stupid oversight in making up the list of new officers of the American Hospital Association for publication in the September number of THE MODERN HOSPITAL, the name of Miss Ida M. Barrett, elected third vice-president at the St. Paul meeting, was omitted. There is really no excuse to be offered for the omission. The only thing we can do is to call attention to Miss Barrett's election as one of the officers.

The choice of Miss Barrett was not only recognition of the merits of a woman who has done much for hospital service, but the association honored itself in honoring her. Miss Barrett has held only one hospital position in her long and useful hospital career. She graduated from the Union Benevolent Association Hospital Training School, of Grand Rapids, Mich., in 1892, and, after taking a post-graduate course in the General Memorial Hospital of New York, was in 1893 appointed superintendent of her alma mater institution, where she has labored ever since.

In her own state Miss Barrett has long ago taken the highest place in the esteem of the people. Her name and influence are to be found in the leadership of almost every fine movement that has for its object the health of the people, and her influence has extended abroad, partly because of the large number of well-trained women she has sent into nursing service and executive work. Her nurses are working in China, Japan, on the battle-

MISS IDA M. BARRETT.

fields of Europe, in the Ghettos of almost every American city, or are ably directing the destinies of hospitals in every part of the world.

It is not given to many women, or men, to be of the broad usefulness to which Miss Barrett has attained, and THE MODERN HOSPITAL is glad to have the opportunity, on this the twenty-first anniversary of her service in the Union Benevolent Hospital, to wish her Godspeed, and more strength, and a long and happy life. As bread cast upon the waters returns after many days, increased an hundred fold, so may the happiness and comfort she has sown broadcast return to bless her with the world's best offerings, and, as she has lifted the veil of sorrow and suffering from many a stricken mortal and made the sun to shine, so may many sunshiny days be for her and those whom she loves.

In a recent monthly report, Dr. Montgomery E. Leary, superintendent of Iola Sanatorium at Rochester, N. Y., Monroe county's tuberculosis hospital, made the statement that of 139 patients in that institution in an advanced stage of the disease, 110 are there largely because at one time they had accepted the dictum of an alleged expert who held that tuberculosis is not contagious. "If tuberculosis is to be stamped out," said Dr. Leary, "not only must adequate provision be made for those already infected, but for those who have wittingly or unwittingly been exposed to the disease. Here it is that we can do a tremendous work in behalf of the children. Every child, as well as every grown person, who has been exposed should have a thorough examination. Every child cared for before the disease reaches an advanced stage means not only one more individual started on the road to health, but one less case of tuberculosis allowed to develop and infect others. It means also a great economic saving in that the cost of the care necessary in the future when the disease will have secured its hold is eliminated, and another life is saved to the community. The whole success of the movement depends on the education of the laity to a realization of the necessity of heeding the first warning of the approach of the disease.

PHILADELPHIA INVESTIGATES ITS HOSPITALS.

Committee of the Philadelphia County Medical Society Makes Report of Survey During Past Year—Some Interesting and Important Findings.

Your committee submitted a report of progress on November 26, 1913. Since that time we have continued to do active work—first, in carrying out the recommendations made in our first report; second, in making a special study of certain important phases of hospital work in Philadelphia; and third, in preparing definite recommendations which will serve as a guide to the efficiency committees which have been appointed at the suggestion of the County Medical Society by more than half of the hospitals in the city.

During the past year we have visited every important hospital in Philadelphia for the purpose of collecting general information in regard to each institution and special information in regard to those which have established social service departments, follow-up systems, and other modern features. In many of the hospitals we have found a very satisfactory degree of efficiency; and, although we present in this report numerous recommendations with the hope of bettering conditions, we desire at the same time to express our hearty appreciation of the splendid work that has already been done by many institutions to make their work efficient.

Conference of hospitals and dispensaries.—Your committee was authorized a year ago to call a meeting of all of the hospitals and dispensaries in the city to consider proposed plans for organizing a movement to increase the efficiency of Philadelphia hospitals. A general meeting was held in the office of the director of public health on December 10, 1913, at which the proposed plans were discussed; and a second meeting was held in the finance committee room in the City Hall on March 26, 1914, at which the plans were further considered, with special reference to the establishment of a central purchasing bureau. At these meetings nearly every important hospital in the city was represented, either by members of its board of managers or by its efficiency committee.

Report on the hospital situation in Philadelphia.—Your committee was authorized to present at these meetings a definite plan for employing a competent efficiency engineer to prepare a report on the hospital situation in Philadelphia. At the first City Hall meeting a plan was presented, but no conclusion was reached in regard to the method of making the study or of securing the necessary financial support, and no one has as yet been employed to do the work.

Your committee believes that it would be of great assistance in paving the way for the proposed local study if some organization with adequate resources at its command would first make a preliminary study of the entire hospital situation in the United States and would define standards by which to measure the efficiency of a hospital. Such a report would provide your committee and the efficiency committee in each hospital in Philadelphia with a working plan for accomplishing the purpose for which they were appointed.

We, therefore, recommend that the County Medical Society indorse the request which the American Medical Association, the American Congress of Clinical Surgeons, and the American Hospital Association have forwarded to the Carnegie Foundation, asking that the Foundation prepare a report on the classification and standardization of hospitals—a report that will perform as great a service for the hospitals of this country as the report on medical education has already performed for the medical schools. We suggest that the president of the County Medical Society appoint a special committee of three members to draft a suitable communication and present it in person to the officers of the Carnegie Foundation.

Uniform system or hospital accounting and statistics.—Your committee was also authorized to invite the cooperation of the State Board of Charities in securing the adoption of a uniform system of accounting and statistics by all of the hospitals in Philadelphia. We met the state board on January 30, 1914, and found them entirely willing to cooperate with the County Medical Society in this matter. They appointed a representative to confer with our representative in regard to the details of the proposed system of accounting. Several informal conferences have since been held, but as yet the committee and the state board have reached no final agreement.

Owing to the absence of any attempt at standardization in the numerous institutions visited, it has been impossible for us to make our medical and financial statistics either complete or accurate. This fact merely emphasizes the necessity for all of the hospitals in Philadelphia to adopt a standard system of records and reports—a system that will furnish an adequate basis for comparing the work of similar institutions and will enable the executive officer of each hospital to present to his managers at frequent intervals a complete report of the work done and the unit cost of this work.

Your committee, therefore, recommends that the County Medical Society express its appreciation of the splendid work that has been done by the Board of Charities to increase the efficiency of institutions throughout the state, and that the society again urge this board to complete the preparation of a uniform system of accounting and statistics, and to use its influence in securing the adoption of this system by every hospital in Philadelphia.

MEDICAL RECORDS AND FOLLOW-UP SYSTEMS.

Summary of information gathered.—In 16 of the largest hospitals in Philadelphia we have made a careful study of the medical record system and secured samples of all of the blanks used. In 31 percent of the hospitals visited the records are kept in such a way that they are absolutely useless for scientific purposes.

Only 3 of the 16 maintain a separate file in which all of the operations performed in the hospital are recorded, and operations of like character are grouped together so that anyone may determine quickly the number of operations performed during a given period, with the results of each. Only 7 of the 16 have any method of making sure that the diagnosis is entered on the record and that the history is complete before the patient is discharged.

The 8 hospitals whose medical histories are scientifically filed use four different systems of classification—2 use an alphabetical list of diseases, 1 the international system of classification, 4 the system devised by the Philadelphia General Hospital, and 1 a special classification of its own.

In 2 hospitals the chief resident physician must check the history before the patient is discharged, in 4 he checks the history before it is filed, while in 2 others the registrar looks over the records at stated intervals. Thus in 8 hospitals some attempt is made to secure the completeness and correctness of the medical records.

Only 4 of the 16 dispensaries in which the record system was studied file all records together in a central record room. In the others each clinic keeps its own records in its own way. In no hospital is the same system of classification used in both house and the dispensary,

and in no instance is provision made for transferring the complete history of the patient from one department to another when the patient is transferred.

Purpose of follow-up system.—A follow-up system properly administered keeps the members of the medical staff in touch with every discharged patient, and thus enables the staff to complete its treatment and to ascertain the results of that treatment.

Recommendations.—Your committee recommends that the County Medical Society take the following steps with a view to accomplishing this purpose:

1. Prepare a uniform system of morbidity records and statistics based on the international classification of diseases and conditions, and urge every institution to adopt the system, with such variations as may be suggested by the needs of individual hospitals.
2. Urge each hospital to perfect its system of medical records so that they will constitute an adequate foundation for the proposed follow-up system.
3. Urge each hospital to keep an accurate record of the condition of patients at the time of their discharge, and to provide for an accurate follow-up of patients after their discharge.
4. Urge each hospital to put in operation a definite plan for obtaining the information desired in regard to each discharged patient in one of the following ways:
   a. By writing at stated intervals to the patient, his physician, or one of his friends who has a permanent address.
   b. By sending a representative of the hospital, at stated intervals, to interview the patient or his physician.
   c. By taking whatever steps may be necessary to insure the return of the patients to the hospital at the proper time for further examination, and in some cases for treatment.

MEDICAL STAFF.

Summary of information gathered.—In 59 of the hospitals and dispensaries of Philadelphia, 1,316 doctors hold 2,291 appointments, 225 holding 3 or more, and a few holding 5, 6, 7, and even 9 different appointments.

Seven of the hospitals visited—including all but one of the teaching hospitals—appoint at least a part of their staff for continuous service. The others maintain a rotating service, in which staff members are on duty from three to six months in each year.

Recommendations.—Your committee recommends that the County Medical Society urge each hospital in Philadelphia—

1. To appoint as visiting surgeons and physicians men who have done and are doing, or who will do, the work required.
2. To develop the medical organization of the hospital toward the point where every member of the medical staff will give continuous service.
3. To retire to the consulting staff chiefs who, because of the calls of private practice or for other reasons, do not give their hospital patients the needful time and attention; at the same time extending to them the privilege of attending patients in private rooms and in some cases in the wards.
4. That members of the visiting staff on duty shall try to determine by personal investigation that food served to ward patients, private patients, and nurses is of suitable quality and properly prepared.

SOCIAL SERVICE.

Summary of information gathered.—Thirty Philadelphia hospitals have established social service departments, although 4 have been discontinued because of the lack of funds. We visited 21 of these departments; 10 are directly responsible to the superintendent, while the others are supervised by special boards and do not form an integral part of the hospital.

In 6 of these departments a social worker secures a social history of every patient who enters the dispensary, and sends the record, with the patient, to the physician. In 6 others, workers secure a social history of patients admitted to only a part of the clinics. In 3 hospitals the social worker is the executive officer of the dispensary. In 14 dispensaries and in all of the hospital wards where social service work is done, only a small proportion of the patients are treated by the social service department, the patients to be treated being selected either by the workers themselves or by doctors or nurses.

There are now 77 paid social workers in the hospitals of Philadelphia. The 60 workers in the hospitals visited handle an average of 3,400 cases per month—i. e., an average of 57 cases per worker—and make 4,400 visits, an average of 73 visits per month per worker.

Purpose of social service.—A social service department properly administered supplements the medical diagnosis and medical treatment by a social diagnosis and social treatment, that makes the work of the doctor more effective and at the same time reduces the average cost to the hospital of treating a patient.

Recommendations.—Your committee recommends that each hospital take the following steps to accomplish this purpose:

1. Establish a social service department as an integral part of the hospital—i. e., place it under the supervision of the executive of the hospital, the superintendent, and provide for its support from hospital funds.
2. Provide that a representative of the social service department shall make a record of the important social facts in regard to every patient admitted to the hospital or the dispensary.
3. Provide for close cooperation between the doctor, the nurse, and the social worker in the treatment of the patient.
4. Provide for cooperation between hospital social service and other social agencies in caring for the sick and protecting the health of the community.
5. Use the social service as a "third arm" of the hospital, that will keep the staff in touch with present and former patients, and, in addition to correcting faulty conditions in the home, will bring back to the hospital discharged patients who are in need of after-care, and dispensary patients who have failed to return after the first or second visit.
6. That hospitals whose funds are not available for the support of a social service department endeavor to raise special funds for this purpose by private subscription.

DISPENSARY ORGANIZATION AND DISPENSARY ABUSE.

Summary of information gathered.—We visited 36 Philadelphia dispensaries; 3 have a social worker as executive officer, and 24 have a clerk or social worker who admits patients to all or a part of the clinics. The patients who visit dispensaries do so for very definite reasons—usually because of their inability to pay for the same grade of service elsewhere. Patients who can afford to pay for private physicians should not visit a dispensary.

Your committee believes that the best way to check dispensary abuse is to appoint a competent executive officer for the dispensary, and authorize him to deal with the problem at the admitting desk, charging a small fee for registration and treatment, which will produce the funds needed for the investigation of those cases which do not present a satisfactory statement when they apply for admission to the dispensary. We believe that by this method it will be possible to check dispensary abuse far more effectively than it could be checked by means of legislation.

Purpose of appointing a dispensary executive.—A responsible executive officer is needed in every dispensary for the same reason that a general manager is needed in every business. He will direct the work of all employees of the dispensary, will decide whether applicants are entitled to admission, will collect fees for registration and treatment, will enforce all rules and regulations prescribed by the managers for the government of the medical staff and the employees, and will help to check dispensary abuse.

Recommendations.—Your committee recommends that each hospital take the following steps to accomplish this purpose:

1. Appoint for the dispensary a competent executive officer, who shall be under the authority of the superintendent of the hospital, and shall be paid whatever compensation may be necessary to secure his services.

2. Define clearly the rules and regulations governing the dispensary, and give the dispensary executive the necessary authority to enforce them.

DISPENSARY FEES.

Summary of information gathered.—Ten of the 36 dispensaries visited charge a fee of 10 cents, 20 cents, 25 cents, or 35 cents for registration, and five others charge a registration fee in the surgical clinics only; 5 charge a fee of 10 cents for each subsequent visit; 6 others charge a small fee for surgical dressings, and 5 of the 36 have fees for special service, as x-ray, etc. In some Philadelphia dispensaries the receipts from fees alone, not including receipts from drugs, amounted in 1913 to over $3,000. In every dispensary making a charge for registration or treatment there is some person with authority to determine which patients shall be admitted without payment of the fee. As far as we can learn, the installation of the fee has in no instance diminished the dispensary attendance.

The Massachusetts General, Peter Bent Brigham, and Boston dispensaries have within the past year increased their fees to 25 cents for registration of adults and 10 cents for children, and 10 cents for each subsequent visit. With 147,000 visits to the Massachusetts General Dispensary last year, the receipts amounted to over $53,000, $29,000 being for fees for registration and treatment, and $24,000 for drugs; while at the Boston Dispensary $30,000 was received as a result of 116,000 visits, $22,000 being for fees for registration and treatment, and $8,000 for drugs.

In 16 of the 36 Philadelphia dispensaries visited a flat rate of 10 cents, 15 cents, or 25 cents is charged for each prescription, while in 13 of them drugs are sold at cost. In 3 no charge is made for drugs and in 3 no prescriptions are filled.

Purpose of charging dispensary fees.—It is desirable to charge a small fee for registration and treatment in a dispensary for a number of reasons. It helps the patients to preserve their self-respect, it opens the dispensary to many who will not ask for free treatment and yet cannot afford to pay a private doctor, and it provides a considerable income, which can be used to develop the dispensary.

Recommendations.—Your committee recommends that each hospital take the following steps to accomplish this purpose:

1. Fix a small fee for registration and treatment in the dispensary, and provide for the collection of this fee by some person who shall be stationed at the admitting desk.

2. Provide that no one shall be turned away because he has no money, and that no one shall be admitted if he can afford to employ a private doctor.

HOSPITAL BUREAU OF STANDARDS AND SUPPLIES.

Summary of information gathered.—We have communicated with the nonresident members of the New York Bureau of Standards and Supplies, asking them to state the advantages or disadvantages of membership. The recommendations have been most hearty and enthusiastic, and no disadvantages were reported. Some of the significant passages in the letters received are as follows:

Johns Hopkins Hospital, Baltimore, 366 beds.—"Our saving is considerably more than the amount of our dues."

Lakeside Hospital, Cleveland, 273 beds.—"The saving on a few items has been sufficient to cover the cost of $200 a year."

Grace Hospital, Detroit, 200 beds.—"We have saved enough during our first year's membership in the bureau in alcohol and whisky alone to pay the cost of our membership for the entire year."

Muhlenberg Hospital, Plainfield, N. J., 100 beds.—"Our connection with the bureau enables us to buy a list of things in small quantities at the very lowest wholesale prices."

Albany Hospital, Albany, 365 beds.—"We have saved on coffee alone in this institution our entire dues and fees."

Pennsylvania Hospital, Philadelphia, 315 beds.—"If we saved nothing, we would gladly pay the fee because of the advantages gained in knowing correct standards for supplies."

Purpose of the hospital bureau.—A Philadelphia hospital that joins the Hospital Bureau of Standards and Supplies in New York will be able to buy a large part of its supplies under general contracts, made by the bureau at the lowest wholesale prices, and with ample guarantees of quality, and in addition will receive from the bureau at frequent intervals reliable information in regard to standard specifications and standard prices.

Recommendations.—Your committee recommends that each hospital take the following steps to accomplish this purpose:

1. Join the Hospital Bureau of Standards and Supplies in New York, at an annual cost of $100 for institutions whose current expenses amount to less than $50,000 a year, and $200 for institutions whose current expenses amount to more than $50,000 a year.

2. Order from dealers with whom the bureau has made general contracts those supplies which can be bought to better advantage in this way; and continue to order from local dealers and others perishable foodstuffs and also those supplies which cannot be bought at a lower price under the bureau contracts.

Conclusion.—In conclusion, your committee recommends that the County Medical Society adopt this report, indorse its recommendations, discharge the committee, and forward copies of the report to each member of the efficiency committees which have been appointed at our request, and to the board of managers of each hospital in Philadelphia, with a letter urging the immediate adoption of the recommendations made.

Your committee asks to be discharged, not because we believe that we have finished our work, but because we realize that this work is of such importance and such magnitude that it is beyond the resources of this committee, or indeed of the County Medical Society itself, to provide the funds and the personal service that must be provided if the work is to be carried to its logical conclusion.

EDWARD MARTIN, M. D., Chairman.
GEORGE E. DESCHWEINITZ, M. D.
ROBERT G. LECONTE, M. D.
CHARLES B. PENROSE, M. D.
WILMER KRUSEN, M. D.
JOHN D. MCLEAN, M. D.
JOSEPH S. NEFF, M. D.
RICHARD WATERMAN, Secretary.

Much praise for its splendid management of the Ohio state hospital was given the state board of administration by State Budget Commissioner W. O. Hefferman, efficiency expert, who recently completed an inspection of these institutions said to have been the most searching ever made. In his report Commissioner Hefferman says, among other things: "I am sure that in no place will there be found a more thoroughly human, efficient, and capable instrument of control than that typified in our board of administration. The old method of conducting these institutions was changed because it was no extremely unsatisfactory in its actual operation. Our hospitals are no longer run for the benefit of inefficient and corrupt powers. The inmates are at home—a home that finally is run for the patient alone. He derives the full benefit of every cent expended on that institution, and in our correctional institutions the inmates are being taught to be of service to their fellows; they are put into condition and acquire the habit of being good instruments. Their ability, energy, and excellence is here developed, and they are sent out into the world again equipped to serve the cause of American individuality, because they have helped to effectively accomplish their own individual emancipation."

CURRENT HOSPITAL LITERATURE

Albert Allemann, M. D., Foreign Literature.
Army Medical Museum and Library, Office of the Surgeon-General U. S. Army.

Frank B. Martin, Domestic Literature.
Army Medical Museum and Library, Office of the Surgeon-General U. S. Army.

Economy in Hospital Administration. Boston Med. and Surg. Jour., October 22.

The State Hospital Commission, in its report for the year ending September 30, states that the elimination of waste and economy in the purchase of supplies has enabled it to keep its expenses within the appropriation for the maintenance of the fourteen institutions under its supervision, and that this is the first year in which these have been operated without a deficit. Modern business methods have made this change possible, and the largest single saving was accomplished in the purchase of fuel, the expense of which item was further reduced by the reconstruction of furnaces and the installation of scientific heating apparatus. The quality and quantity of foodstuffs have not been diminished, but economy has been effected by standardizing the supplies and purchasing them in strict conformity with the requirements of the estimate law. The care of the 32,000 insane required approximately $7,000,000.

Effect of Lightning on a Reinforced Concrete and Steel Dome. C. D. Perrine, Science, Philadelphia, 1914, XL, October.

The increased use of reinforced concrete for buildings and the effects of lightning on a metal dome surmounting walls of this construction become a subject of general interest. The writer cites an instance where a steel dome, sheathed with galvanized iron, was the point of discharge for a fairly heavy flash of lightning, the induced currents in the light and power lines being sufficiently heavy to blow the fuses in both. It became a severe test for such construction—a metallic dome surmounting concrete walls heavily reinforced with iron, the metal in the walls having a good ground connection and being connected also with the dome. The conclusion is to be drawn that, after the resistance of the air was broken down, the dome and metal in the walls were ample to carry off the discharge without the slightest apparent damage to either the structure or a man who was in the dome at the time.

The Value of the Library in Hospital for Mental Disease. Edith Kathleen Jones. Maryland Psychiat. Quart., 1914, IV, 8.

The writer, while conceding the advantages of access to public libraries in large cities or towns, claims the great thing in a psychiatric hospital is its own library; that each hospital should have one, however small, with at least a few new books added as frequently as possible, and someone—librarian, officer, or patient, the best available—to see that the books reach the patients and accomplish their purpose of recreation or education. The public library may be drawn on to supplement the institution's library, but the best results are to be obtained from books which are at hand when they are wanted.

The Newer Mission of the Doctor and Hospital. John Punton, Pacific Med. Jour., San Francisco, Cal., 1914, LVII, 477.

In taking a retrospective view of the principal features that characterize the present age, the author believes it is a part of the newer mission of doctor and hospital to bring about desirable changes, that the hospital, dispensaries, and even medical practice itself can become better equipped for the greater medical, moral, social, human welfare public duties. The real function of the well-equipped modern general hospital is no longer considered as an exclusive medical monopoly, or private concern, even when owned and controlled by private interests. Moreover, the modern hospital must not be recognized as a great commercial plant, where only the good-paying cases are received and discharged, and where physicians, surgeons, pathologists, and specialists are most tempted to enter into envious and bitter controversies. The members of the profession who have at heart the best interests of the hospital believe that, independent of its strictly technical, scientific, medical, and surgical detail, the work of a modern and efficient hospital should include a close study of the social, humanitarian side of disease and suffering, and that more strict attention be paid to the investigation of worthy and unworthy applicants, including their social and moral status, as well as other conditions that underlie the pathogenesis, the spread, and continuance of disease. The large welfare work of a modern general hospital and dispensary includes not only its purely scientific, medical, and surgical work, but also the rigid expert investigation of the social pathogenesis of disease and suffering. It is no longer regarded as a dispenser of charity, even though the medical services are free or shorn of monetary consideration. Its functions are now sufficiently enlarged to include a great and responsible charge and philanthropic duty, by its protection of all citizens from not only the menace of uncontrolled contagious and loathsome disease, but also the ravages of epidemics. So considered, this newer mission of the doctor and hospital becomes a golden link in the great chain of the larger humanitarian social service welfare work now being inaugurated throughout the country.

Hospitals in Brussels. Pacific Med. Jour., San Francisco, Cal., 1914, September.

The editor furnishes an interesting account of Dr. Depage's private hospital in Brussels, a new three-story building of gray brick and sandstone. "We were at once taken to the third floor, where we changed our coats for operating gowns," says the author. "We were then conducted to a well-designed and magnificently equipped operating room, in the center of which stood a large permanently fixed operating table of the French or Swiss type, fitted with hydraulic lift and innumerable other adjustments. We had all been required to incase our feet in cotton bags, and were soon floundering about like so many Eskimos on snowshoes. The surgeons protect their beards (and most of the surgeons of the French school possess the latter in growths of wondrous luxuriance) by a strip of cotton sheeting suspended from a bar stretched across the bridge of the nose, looking not unlike the yard and mainsail of an old-fashioned square rigger. Rubber boxing gloves were worn upon the hands, the usual explana-

tion being offered that they were cheaper than the thin and only sensible variety. It is beyond comprehension that our ordinary American surgical glove should be more expensive than the one used by the French and Belgian surgeons, for surely the latter contain sufficient stock to make enough gloves to last an American operator a couple of years. The clumsiness of these articles, precluding all possibility of dexterous work, renders obvious the valuelessness of the explanation for their use. At the elbow of each surgeon were two large cans of hot and cold sterile water, and these could be drawn from at will by the operator using the sterile handles. Ether was the anesthetic given, and was administered by the drop method on a modified Esmarch inhaler. The operating room nurses were bare-armed, and wore thin cotton gloves, a type a little worse than none at all. The patient operated on was a woman who presented certain vague gastric symptoms. The abdomen was opened and the viscera explored. Nothing grossly pathological was discovered. However, a gastroenterostomy was performed, the operator following practically the old technic of Roux. The abdomen was closed with interrupted, through-and-through silk sutures. The patient was then turned on her side, the loin opened, and a movable right kidney exposed and fastened into position. To accomplish this the operator passed six large catgut sutures directly through the center of kidney substance, and fastened these in the adjacent lumbar fascia. After the operation was completed, Prof. Depage showed us about his hospital. In the sterilizing room was seen the complicated apparatus which we had noted in all French hospitals. The corridors of the institution are laid in terrazo, and have been down six years without showing wear. The walls throughout are of enameled plaster, and all rooms are provided with sanitary coves and bases. In the basement we were shown the kitchen and the laundry. The little hospital contains 18 beds, and the entire plant is, for the most part, scientifically and completely equipped.

New Bed Bath Tub. E. A. Gallegher, New York Med. Jour., 1914, October 24.

The invention is for the purpose of reducing temperature, and to be used as a substitute for the portable bath tub in general use in typhoid and sunstroke cases, delirium tremens, nephritic cases, scarlet fever, paralysis, bedridden cases, rheumatism, severe burns, or where a full saline bath is ordered. The tub may also be used for any medicated bath, and also for vapor baths and a hot bath following. This tub can be hung up in the bath room, thus occupying a small amount of space, and will relieve the nurse of lifting the patient, and save the patient the inconvenience of being moved about and handled unnecessarily. It is semicircular, made of light tin, and can be carried very conveniently by the nurse or attendant. It is placed at the patient's back and he rolls in on the side. When the bath is completed, the water is drained off, and the tub is turned on the side, thus allowing the patient to roll out on the bath sheet, which is spread over the bed, the tub is removed and the patient is covered up. It will be a useful article for the bathing of scarlet fever cases, enabling patients to have their bath in bed instead of getting up and going to the bath room, which many people consider unwise, especially if the heart is weak.

The Terek (Caucasus) Leper Hospital from 1898-1913 (La leproserie du Térek (Caucase) de 1898-1913). Dr. Keraval.

This leper hospital was established in 1898. At first it consisted of six small houses for the patients, a small church, and a dwelling for the director. Gradually five more houses for the patients and other necessary buildings were added. The grounds comprise forty-eight hectars (115 acres). At the head of the institution is a medical director, assisted by two physicians. During the fifteen years of its existence the hospital treated 58 men and 42 women. Of these patients 44 died and 6 were cured. At present there are 24 men and 17 women at the institution. The annual expenses are 15,000 rubles (about $8,000).

Preventive Inoculation Against Typhoid Fever of Physicians and Nurses in Hospitals (Typhusschutzimpfung der Aertzte und Pflegepersonen in Krankenanstalten). Ztschr. f. Krankenanst., Leipzig, 1914, X, No. 38.

During war times there is always danger of typhoid epidemics, and all possible preventive measures should be taken. For this reason the minister of the interior of Prussia issued a circular in which he advises the physicians and nursing personnel of all hospitals to submit to antityphoid inoculation. The typhoid vaccine is furnished gratis to all hospitals by the Robert Koch Institute for Infectious Diseases in Berlin, with instructions how to carry out the preventive inoculation.

New Haven Hospital Management.

As noted in the Boston *Medical Journal*, the change in hospital management, and the more intimate relation being established between hospitals and medical schools, is exemplified by recent action of the New Haven Hospital. On condition that Yale University would raise a large sum for new buildings and endowment, it was agreed that the New Haven Hospital would be taken over by the university, and used in connection with its medical school as a university hospital. The hospital is to be under control of the medical school, and the services of its appointees are to be continuous, after the plan of Boston institutions—the Johns Hopkins Hospital and others. In addition to the present hospital at New Haven, an approximate fund of $750,000 is to be devoted to the construction of a special hospital for tuberculosis, to be situated in the outskirts of the city on a tract of land, which will form part of the general hospital plan. Dr. Simon F. Cox has been appointed superintendent of the enlarged institution.

Gouverneur Clinic.

In the October number of the *American Journal of Nursing* an interesting resume of the work of the visiting nurses of the Gouverneur Clinic is given by Winifred W. Allen and Elizabeth McConnell. The basis of the report was the patients who attended the clinic during the year 1912 and who had been under clinic care or nursing supervision for six months or more. Despite difference in race, religion, and language, the overwhelming majority of the patients proved to be teachable in the essentials of personal hygiene and prophylaxis, and most of those whom the clinics trained for six months or more both learn and practice what is taught them. The conclusion is drawn, therefore, "that no class can be looked on as wholly unteachable, and that time and persistence yield a surprising percentage of good results even with the least promising cases." This is distinctly encouraging for all who are engaged in public health education and holds out promise for excellent results.

The Anthony Hospital, Anthony, Kan., was destroyed by fire recently. The building was owned by Dr. Walker, of Harper, but had just been vacated by Dr. Hatch, who had been conducting the hospital.

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HOME-MADE HOSPITAL APPLIANCES

Harper Hospital Toilet Carriage.

DESIGNED BY WAYNE SMITH, M. D., SUPERINTENDENT HARPER HOSPITAL, DETROIT.

This carriage has been in use for ten months in the wards of Harper Hospital, and has proven very satisfactory. It is a labor-saving device for nurses, as it saves many steps and at least one hour's time of each nurse when attending to the patients' toilet in her care in the mornings and afternoons. It is very serviceable when a patient needs a full bed bath, as hot water is available without the necessity of the nurse leaving the patient, and

Fig. 1. Hospital toilet carriage—1, hot water tank; 2, outlet for hot water; 3, waste water tank; 4, waste water funnel made to fit a basin; 5, clean out; 6, porcelain top; 7, towel railing; 8, intake for hot water.

is also useful in mornings after the patients' toilets when doing ward work, such as cleaning bedside tables, etc., the probationer's duty. The carriage is also used daily as a surgical dressing carriage when the surgeon makes his rounds, enabling him to go from patient to patient without the necessity of leaving the ward to wash his hands. The carriage is simple and light in construction, easy to clean, can be manipulated very readily by the nurse or orderly.

Fig. 1 shows the carriage, with a nickel-plated towel rack, a porcelain top, and a nickeled copper tank, which is removable and holds twelve gallons of hot water. Below the clean water tank is the waste water tank, which is so constructed that it can be cleaned out from the top. On one end is the waste water funnel (*4*), and above this funnel is the intake for the clean water (*8*). The intake has a nonloseable cap, with a chain.

An orderly fills the tank with hot water in the morning, places the basins, soap, and wash cloths on the top, and hangs the towels on the towel railing. The carriage, when to be used, is pushed into the ward, and the nurse takes a basin of clean water, soap dish, wash cloth and

Fig. 2. Hospital toilet carriage—Shows the carriage in use.

towel to each of those patients who are able to wash themselves, and those who are not able to wash themselves are cared for by the nurses. The early morning ablutions begin one hour later, when this carriage is used. A piece of rubber tubing attached to any faucet will suffice to fill the tank.

This home-made toilet carriage has been in use also at the St. Louis City Hospital for some time.

The national headquarters of the American Red Cross has received recently from United States Ambassador Gerard, at Berlin, an appeal for American financial support of the American hospital lately organized in the Prussian capital to care for German wounded. It is claimed the Red Cross cannot at present meet this request owing to its limited funds, but hopes through the generosity of the American people soon to be able to do so. According to a statement from its headquarters, the contributions already received by the American Red Cross for the relief work to be prosecuted on behalf of the sick and wounded of the various nations involved in the great European war total approximately $300,000. This sum, it is stated, is far under the amount needed for this great work. The cost of maintaining the relief ship recently sent abroad bearing nurses and surgeons to the warring countries is alone $15,000 a month, and this is but one of the ways in which the American organization hopes to help the cause of humanity.

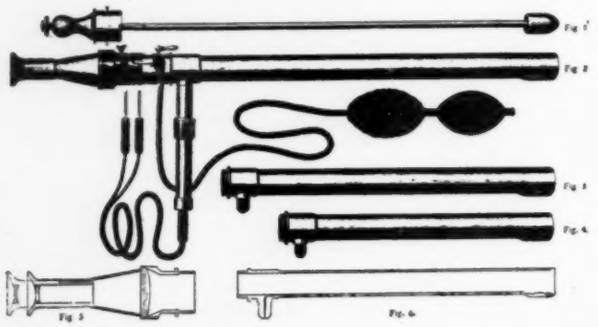
Miss Lena Voss, a recent graduate of the Hackley Hospital training school, Muskegon, Mich., is the new superintendent of the mission hospital of the Christian Reformed Church of America at Rehoboth, N. M. The hospital is situated at the principal mission station of the denomination in the Navajo-Zuni Indian field, and receives both white and Indian patients.

NEW INSTRUMENTS *and* APPLIANCES

Vincenz Mueller, Technical Editor.
Geo. W. Wallerich, Associate Editor.

Dr. O. Ringleb's Proctoscope.

The proctoscope here shown embodies several new features which commend it over many existing types. With most of the present electrically lighted proctoscopes it is difficult at times to make a satisfactory examination for the reason that either the illumination is weak, the light being thrown from a lamp which is placed too far from the part under observation, or, if the lamp is in the distal end of the tube, often the illumination is interfered with through dressings which are caught by the lamp in making applications. The Ringleb proctoscope seems to overcome these objections. The miniature lamp is mounted



Ringleb's proctoscope and sigmoidoscope, with telescope and inflating attachment.

within a recess at the side of the proctoscope tube and at the operating end of the instrument, and thus the illumination is in no way interfered with.

Another addition has been made in which examination is rendered more satisfactory—namely, the magnifying eyepiece. This eyepiece is adjusted so as to accommodate the various lengths of tubes, which are supplied in lengths of 20, 25, and 30 centimeters.

Electrical connection is made by a metal sliding contact switch, which screws on, and can also be used as a handle for manipulating the tube. An air cock, with dilation bulb, completes the instrument.

A New Tourniquet.

BY DR. RUTHERFORD B. H. GRADWOHL, ST. LOUIS.

The use of an efficient tourniquet has become rather important since venu-puncture for the purpose of withdrawing blood for Wassermann tests and salvarsan injection have become so popular. In some cases the old time-honored method of tying a piece of rubber tubing about the upper arm will suffice in making the veins stand out prominently, yet there are cases where this is not possible—for example, in individuals with great accumulation of fat on the arm, or on women who do not have prominent veins, as well as on small children. In such cases it is necessary to use a tourniquet that will give a uniform and efficient compression—one that can be readily adjusted and, what is of greater importance, that can be

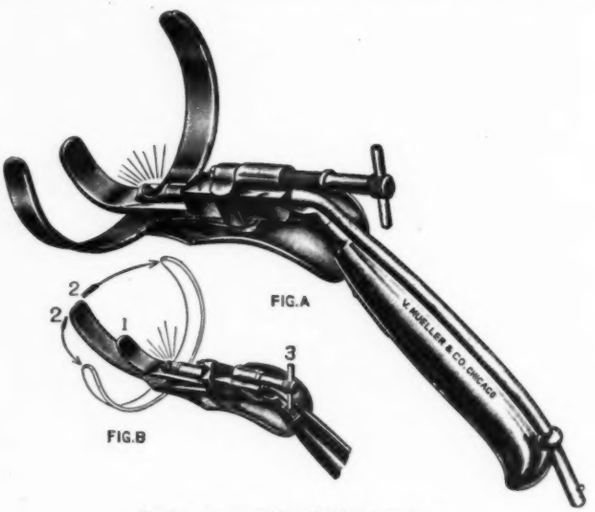
Gradwohl tourniquet.

readily removed without fear of dislodging the needle from the vein.

The tourniquet illustrated here seems to have all these advantages, inasmuch as the slip catch on this instrument permits the operator to insert the needle into the vein, hold it tightly, and release the tourniquet with one motion.

Suprapubic Bladder Retractor.

This instrument was devised for the purpose of assisting the surgeon in his bladder work. When folded (Fig. B), it can be introduced through a small suprapubic incision, as it does not occupy any more space than the index finger. As the bladder is capable of being dis-



Corbus suprapubic bladder retractor.

tended to a greater degree in the transverse diameter, this instrument is especially valuable in examining the internal urethral orifice before and after prostatectomy, in suturing over the cut surfaces of the mucosa after

prostatic enucleation, excising of tumors, and, in fact, in all intravesical operations.

The instrument consists of the shaft, with quick-thread screw for extension of the blades; the wide posterior abdominal retracting blade; two sets of folding blades, and the light carrier, which is supplied with a so-called cold tungsten bulb, furnishing a white, brilliant light. All points are carefully rounded to prevent injury to the parts, and the connections are all slip-joint, so that the blades may be quickly exchanged and the instrument taken apart for sterilization. The extension possible with the small blades is 7 centimeters, and with the large blades 11½ centimeters.

Operating Table with Adjustable Top.

When visiting hospitals abroad, one will see in many operating rooms, especially in France and Germany, elaborate and complicated operating tables, which seem to be very much at variance with some of the other simple and, in some cases, meager equipments. The cost of these tables with the complete array of attachments is so high that American surgeons and hospital superintendents, with few exceptions, have refused to consider the purchase of such tables in the past, although they acknowledged that some of the features incorporated in them are desirable and superior to those ordinarily used in our institutions.

The principal advantages of these tables are (1) that the top can be adjusted to a height to suit the stature of

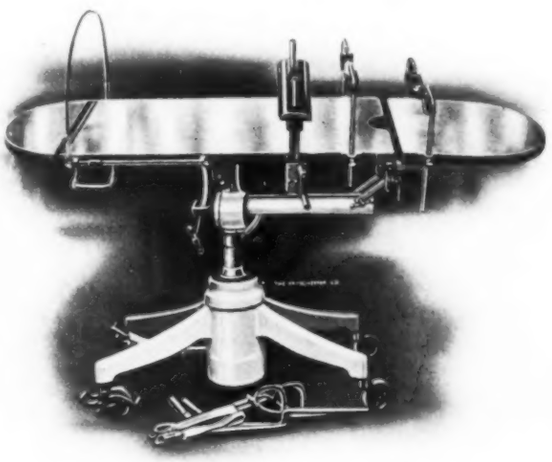


Fig. 1. Adjustable table in flat position and showing various attachments.

the operator; (2) that the top may be rotated, either for the purpose of securing better illumination of the field of operation or for the exhibition to the clinic without changing the location of the table; (3) that the top may be tilted, which is a great advantage in some cases.

The table illustrated here is made in this country, and has been simplified to a considerable extent from the complicated pattern, thus reducing the cost without sacrificing any of the desirable features. The strong, heavy base is supplied with an oil pump and the top is adjustable from 32 to 38 inches in height. The top is made of an alloy of metals impervious to all solutions used in surgical procedure. The base is white enameled, and the various fittings, such as heel stirrups, leg rests, shoulder rests, ether screen, etc., are nickel plated. An elevating bridge for use when operating on kidney or gall bladder cases is provided, and the bridge may be quickly removed when not required. Special features may be added, such as a bridge for elevating the neck in goiter cases.

With the table are adjustable lateral braces to prevent

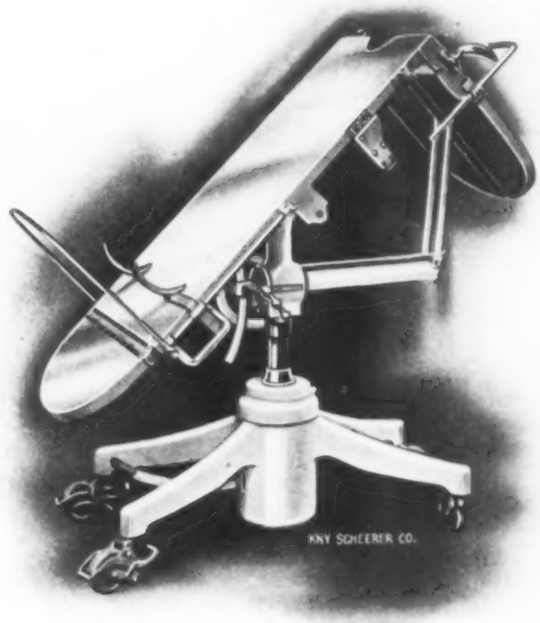


Fig. 2. Adjustable table in Trendelenburg position.

the patient from slipping off the table when treated laterally, and foot supports when in reverse Trendelenburg position.

The top of the table may be quickly changed by the

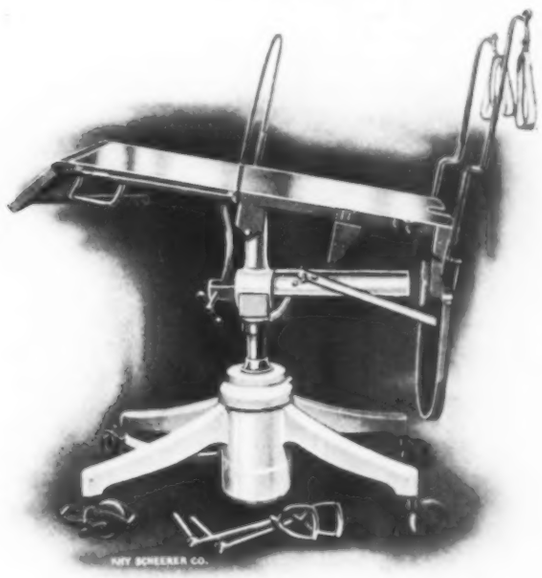


Fig. 3. Adjustable table in position for head or neck work.

anesthetist to any required position and securely locked. Two of the heavy rubber-tired casters are provided with foot brackets to hold the table rigid during an operation.

DEPARTMENT *of* NURSING

Mary M. Riddle, R. N., Editor,
Superintendent Newton Hospital, Newton Lower Falls, Newton, Mass.

Encouragements.

The nurse's work is constantly growing in favor. Public schools and colleges are paying attention to its possibilities and opportunities, and some colleges are offering courses preparatory to the nurse's work in the hospital or interspersed with it, while public schools are directing the courses of their students with a view to fitting them for the nurse's work on completion of the public school course. While all this is but the natural trend and does not mark appreciation of what has been done, it does show a realization of the need for adequate preparation, and is just in line with the arguments put forth by this association and all those who believe in a preparedness before entrance to a training school is gained.

Nurses all over the land owe much to the standards of the Red Cross. This great organization laid down the requirement that a graduate nurse, to be accepted by them, must first be a registered nurse, and she must also be a member of her state nurses' association or other organization for promoting the interests of the nursing profession and advancing its standards.

Inasmuch as membership in the Red Cross has become very popular, this has been a powerful incentive to nurses to attain an excellence in their work, both theoretical and technical, and is an indication that states must attain and maintain standards such as we are struggling for at the present time.

All along the line are found reasons for encouragement and proofs of the statement that the day will surely come when the advanced standards of today will be but minimum requirements.

Nothing more convincing or more encouraging for the future has recently come to notice than the reports from participants and descriptions in the secular press of the recent celebration of the twenty-fifth anniversary of the opening of Johns Hopkins Hospital. Those fortunate enough to be present and enjoy the various forms of celebration were impressed with the part taken by the nurses, who shared and shared alike the courtesies and honors with the other professional people present. The press, after paying just and fitting tribute to the medical school as such and to the hospital as such, dwells at greater length on the school for nurses, saying that the new profession of the trained nurse has almost literally grown up during the life of this hospital, for it says:

"In 1889 there were not in the whole country, outside of hospitals, more than a few hundred trained nurses; now their number is estimated to exceed a hundred thousand, and the standard of qualification is steadily rising. To the development of that calling, and to the lifting of it to a higher professional place, the Johns Hopkins Hospital contributed powerfully. The training school for nurses was started simultaneously with the hospital itself, and it at once took a commanding position in its field, and had the effect of stimulating the growth, multiplying the number, and greatly raising the standard of training schools for nurses throughout the country.

"In this, as in other matters pertaining to modern progress, we take present advantages for granted, and are more prone to complain about their not being greater or more general than to dwell on their being in our possession at all."

We complain of the slow rate of progress—but is it really so slow as it seems when we stop to consider what has been accomplished in these twenty-five years? History is repeating itself—a little more than forty years ago women began pleading with cities and towns for the privilege of nursing their sick in hospitals. The privilege was granted slowly, reluctantly, and but a little at a time. Today we are asking the state to permit us to demand that the same work be better done, and our request is granted but a little at a time, though sufficient to make progress.

From the devotion of the women of forty years ago may we get our inspiration. May *we*, like them, have faith that devotion to our cause (which is ultimately better care for the sick) must be our one pure, passionate purpose that, with a continued effort, a regular effort, and a concerted effort, shall eventually bring success.

Again the Eight-Hour Law.

At the risk of appearing hard and unfeeling, as well as unprofessional, there are nurses who deplore any discussion on the subject of an eight-hour law in hospital training schools. The feeling is not engendered by want of sympathy for nurses who spend long and tedious hours in the wards of the hospitals while in training, but by the fear that the reduction in time may not be conducive to good training.

When it transpires that long and tedious hours must be spent with a patient in order that he may have the steady, persistent, continuous care so necessary for his restoration to health, will it be reasonable to expect that he will be given unstintedly the time required so long as the force of habit is against it?

The old-fashioned custom of considering the nurse a soldier had the advantage of giving the impression that, no matter what the exigency, hers "not to reason why," hers but to accomplish the task in hand, regardless of time and effort. While that is an extreme to be deplored today, it was a demand of the times that had to be met.

The eight-hour law in the hands of the unscrupulous or ignorant is a decided disadvantage, and might even be a backward move on the march toward higher standards. On the other hand, it might prove a blessing in disguise and an impetus toward higher ideals.

An eight-hour law, as such, is no particular benefit to anyone, whether he be a labor unionist or professional worker, unless the additional time thus put at his disposal be well spent. The average laboring man makes overmuch of his so-called rights in the matter; he does not spend the time to his advantage and has therefore cast aspersions on the whole system. The wise and thoughtful man makes good use of the additional hours, and for him it is a blessing.

The wise and thoughtful nurse will see in the plan an opportunity for improvement of herself and her condition, and to her it will be a benefit while in training. Just here one sees a necessity for a discriminating selection of pupils. It has long been known to superintendents of training schools that the well-bred and well-educated nurse has least to say about long hours and menial tasks—

she recognizes nothing menial, and the hours are none too long for the accomplishment of what is required. With this spirit she is safe, and, with a spirit of this kind prevailing, any school is safe, and to it the eight-hour law may be a blessing. If the same spirit goes with the nurse into private practice, no fragments of remembrances of an eight-hour day will hamper her usefulness. She is then a professional, and is not giving great consideration to time, but rather to usefulness and success.

Dr. S. Weir Mitchell expressed the idea that nursing could never be called a profession until those practicing it were willing to make everything subservient to the real needs of the sick—time, compensation, position—everything.

The conclusions to be drawn from the effects of this new law, and the evident desire for a pretty general practice of it, are:

1. It makes necessary a more careful selection of pupils and the maintenance of even higher standards in the schools.

2. The cultivation of a more truly professional spirit in the personnel of the schools.

Discomforts of the Unnecessary—Plea for Collarless and Bibless Uniforms for Nurses in the Summer Time.

BY MRS. J. E. COX, ROUND LAKE, NEW YORK.

Who started the custom of adding unnecessary accessories to the uniforms of workers in public institutions, or, more pertinently, who insists that these uncomfortable accessories shall be maintained in hot weather?

When all the rest of the feminine world is robed in thin, low-necked and short-sleeved dresses in an effort to be comfortable, the hard-working nurses in many hospitals and the attendants in various state institutions have to be neckbound with stiffly starched boardlike collars until every suffering neck has a well-defined "streak," that sometimes is almost a ridge, made by the irritating friction of the top edge of the collar against the flesh.

I have talked with different workers about it, and have found the expressions of discomfort universal, and I have also found some who confessed to discarding the collar a few minutes at a time for a respite, but always on the alert to replace it quickly at the approach of a superior officer. I personally knew of a woman working in a hot kitchen in a state institution, whose neck became extremely sore and blistered during a time of excessive heat because the wearing of the collar was a cast-iron rule. Wherein is the reasonableness or the need of this custom, so replete with discomfort?

Why should not the law of the uniform have as its largest factor for consideration the comfort of the wearer, and what interest is conserved (except that of the collar manufacturer) in making a hard-working girl wear through the sweltering summer a high, hard, hot, and air-impervious band around the neck? Could we assume the authority of a Portia, we would say, "Let the perpetrators of this requirement be brought to justice, and let them be convicted and sentenced to hard labor at a sweltering temperature for an indefinite period, with their necks incased in layers of starched linen, until they repent of their cruelty and learn to be humane, and in the process get an infusion of sympathy."

During the hot summer months, why should not the uniform be made with a comfortably low-cut neck, neatly finished with a band of white instead of the ever-required stiff collars? We venture the assertion that the style of uniform that now obtains of stiff collar and apron bibs of heavy muslin almost like an added waist was not designed by one who "came up from the ranks," but in some official sanctum where the consideration of appearance has been the ruling factor to the exclusion of comfort.

We know of an institution where the nurses are allowed to wear wide turn-over flat collars through the summer, but in the same institution the women attendants and general workers have to wear the stiff Roman collar, slanting in toward the top, with its cutting edge, and of course wearing long-sleeved uniforms, with a boardlike white cuff.

There are few places this side of an alleged purgatory where heat is more intense than in a steam drying laundry, yet we know that women superintending these rooms have to endure this heat, having to obey the required law of wearing the uniform just mentioned.

What a boon it would be to all these workers if some person in a place of power should have independence of spirit enough to cut loose from the traditions of the fashion that now obtains, and think of these workers as being made of flesh and blood, sweltering unnecessarily because of useless and uncomfortable accessories of uniform. Why should it not be reasonable that the neck be cut low and neatly finished for a summer uniform, the sleeve be made of elbow length, and the apron bibs (if they must be retained) made lower and narrower? A recognized uniform is a necessity, but there is no inherent virtue in stiffly starched linen, and a new style of uniform, like a newly fledged government, simply needs to be recognized by the "powers" to have all the authority and impressiveness of that which it has displaced. In the historical past a simple voice crying in the wilderness for the straightening of the way has wrought a reformation of greater import than that of mere physical comfort.

We are not out with banners for a great reformation, but simply voicing a sympathetic interest for uniformed wage earners, and wishing we might cause an arrest of thought that would lead to a change of summer attire, or more elasticity in the present requirements during the heated term, to the increased comfort of thousands of workers.

Where There Is No Shortage of Probationers.

A contemporary, in speaking of a hospital and its accessories, refers to its training school for nurses in terms of praise. It says it is one of those schools fortunate in having a long waiting list of desirable applicants simply because its fame has gone abroad. It acquired its prestige largely through its connection with the university college; it also at the same time gained that which made its pupils proficient in their own sphere—namely, good teaching and practice—but, besides all that, it has a recognized standing as a student body. The college professors and their families are as much interested in this branch of the work as in any other. The student nurses are well provided for in their nurses' home, have pleasant and comfortable rooms, are well supplied with periodicals and other good reading, and are altogether happy as well as useful.

The first cost of maintaining a training school in such manner is considerable, but not beyond the equivalent rendered, and is not to be compared with the sense of security for the care of the sick, who are the responsibility of the institution. It is the same old story, with perhaps a little different application—in common phraseology, "we get what we pay for." If we want a good article, we must pay the price. If we expect to get good women to train to be good nurses, we must meet the expense.

QUERIES and ANSWERS

More About the House Count.

To the Editor of THE MODERN HOSPITAL:

I thank you very much for your reply to my query with reference to the house count. After considering the matter, I am sure you are right in saying that according to our method we are taking credit for more than the actual number that pass through the house. The better way would be, as you suggest, to consider the stay two hospital days only in cases where the patient is in the house more than twenty-four hours.

I would say with reference to our charges, however, that, for the purpose of making the bill, we have always considered the day the patient was admitted and the day he was discharged as one day.

There is just one point about which there is still a question in my mind, and that is whether in giving the number of patients in the hospital on any certain day it is correct to give the number as taken by the midnight census plus discharges, provided day of admission and discharge is more than twenty-four hours, or whether the actual census should be taken as the number.

H. E. BISHOP,
Superintendent Robert Packer Hospital, Sayre. Pa.

It seems to me the house count should be taken once a day only, and should be an actual census of the patients present. It is taken at midnight, because that is the natural point of separation between two days. Barring emergencies, the house is settled down, and, even if a patient comes in at evening and leaves early in the morning, he will have had practically a "day's treatment"—a bed, clean linens, admission attention, and medical and nursing care, and the hospital should be credited for him.

But there will be in most hospitals that receive paying patients a small percentage of border-line cases which should be subject to individual treatment. In most hospitals the technic of discharge prescribes that the head nurse or someone acting for her take the house record of the patient to the office as soon as the order for his discharge is issued and before he leaves; this permits the clerk to make out the bill and to note any special charges or any deviation from the ordinary routine of the institution.

This sending of the record to the office as a warning that the patient is about to leave serves another excellent purpose. Sometimes a patient is discharged by his physicians, for whom special arrangements have been made with the office for getting him to his home without allowing him to go alone. Most of us have had experience with patients who set out alone for their homes, apparently in good condition, but who were overtaken on the way with a sudden seizure. Such a thing is extremely embarrassing, and difficult to explain at best. If perchance the office had been warned by the relatives of the possibility of such a contingency, and arrangements had been made for calling a cab or sending an orderly with him, no explanation would suffice. There will not be enough of these border-line cases to seriously upset the routine or to harass the bookkeeping department.

Methods in the Training School.

To the Editor of THE MODERN HOSPITAL:

We are about to reorganize our training school for nurses, including the rearrangement of its lecture staff. I would be greatly obliged to you if you would give me the benefit of your opinion concerning the proper organization of a training school for nurses in a manner to preserve its distinctiveness as one of the units of the general organization of the hospital of which it is a part. My opinion is that the training school for nurses of every hospital should be a separate and distinct unit, so far as organization and administration are concerned, and should be, therefore, under the direct supervision and control of the administrative branch, and responsible directly through the superintendent of the hospital to the board of trustees or its executive committee, and that, although connected with the visiting staff and lecture staff for professional instruction, it should be entirely independent of it in administrative and disciplinary measures, which should, in my judgment, be placed entirely in the hands of the superintendent of the hospital and superintendent of nurses.

1. In connection with the professional instruction of the pupil nurses, may I ask if there should be a lecture faculty, so-called, of the school, and to what extent, if any, should members of the visiting staff be connected with it?

2. Should there be a dean of this faculty; if so, does he present the candidates for graduation to the president of the hospital or to the chairman of the school committee at the commencement exercises of each class as it graduates; if not, who does?

3. At the examination of each class as it is advanced to the next grade, and at the final examination for graduation, who determines (after the markings of the examinations are handed in) the eligibility of the candidates for advancement or graduation—i. e., the lecture staff, the visiting staff, the superintendent of the hospital and principal of the training school, representing the training school committee, or the committee itself?

AN ADMINISTRATOR.

There is no doubt in my own mind that the training school should be considered as a distinct unit of the hospital, but it should be as closely related to the hospital as the bookkeeping department, or the kitchen, or any other unit that is necessary to the administration of the institution. The chief purpose of the hospital is to care for the sick, and the training school is one of the agencies by which this is done. The superintendent of the hospital is the responsible agent of the board of trustees concerning the primary purpose for which the hospital is conducted, and in my judgment he cannot be held to an accountability unless he has broad authority conferred on him by his board. Only in that way can the abilities of an administrator be measured and his greatest usefulness attained. The wise administrator will know how to use his authority, and, in so far as the training school is concerned, will exercise only a general supervision to see that patients are properly taken care of and that the teaching of the pupil nurses is properly done. No administrator can escape responsibility thus far.

The visiting medical staff should exercise no administrative functions in the hospital. If the patients are not properly nursed, if their orders are not properly executed, their recourse is to the superintendent of the hospital, and, if that official is unable to meet the demands, the final appeal is to the board of trustees itself. I see no good reason why a staff member may not go directly to the head of the training school for satisfaction concerning some dereliction or inefficiency in the nursing, but he has no right to hold the training school head responsible, except as better cooperation is often to be had by intimate touch between the people who are actually doing the work, as, for instance, the doctor, the intern, the head of the training school, and the pupil nurse. But the visiting doctor has no right to raise a row with any of these people; he should go directly to the superintendent if there is to be any unpleasantness.

1. I have some notions about the teaching of pupil nurses that are regarded by a good many leaders in nursing as unique and perhaps even obsolete. I don't think, for instance, that a pupil nurse can be properly trained unless some work in her training is given by the doctor whose patient she is taking care of. I don't believe that a nonmedical person, even though a teacher in the training school, is the best teacher for a nurse in the things that stand for medical care of patients, and I imagine that a great many teacher-nurses would agree with me in the main. The trouble is that the attending medical men have never the time, even if they have the inclination, to give that individual attention to the training of pupil nurses that is so necessary. I think that is the reason why, in a great many schools, the training school has practically despaired of getting any help from the medical staff in the training of nurses. The medical men simply will not give the time and attention and thought to the work that it requires, and the teacher-nurses are compelled to do the best they can without this help. I think the head of the training school, with the approval, or, rather, the cooperation and consultation of the superintendent of the hospital, should make up the teaching faculty of the training school, and that the training school committee should have the final approval of the result. With a wise and thoughtful superintendent and an experienced training school committee, the head of the training school will have some excellent counsel, and eventually some strong backing that she may need on occasion. I think that such studies as the fundamentals, anatomy, physiology, materia medica, surgery, and the principles of obstetrics and internal medicine (that is, the cause, course, and treatment of medical diseases) should be taught by the teacher-nurse. I think the medical faculty should give very short clinical courses of instruction on medicine, surgery, obstetrics, diseases of children, and the specialties; these should be taught in illustrated or clinical lectures when possible, but these lectures should be rather a finishing-off of the other courses taught by the teacher-nurse, and each lecturer who undertakes a course of this kind should know just exactly what the pupils have been over in their text-book work. If he is a good lecturer, he will be able to give them a vast amount of interesting and valuable information, and in a way that will leave an imprint on their minds. There are some medical men who have the proper viewpoint and who make most excellent teachers of the "ethics of nursing," but not every medical staff contains such a member, and, where there is not such a medical man available, the ethics of nursing will be better taught by the head of the training school.

2. In very few hospitals do the medical faculty members have anything to do with the examinations or the promotion of pupil nurses. Usually the head of the training school reserves all rights in this connection to herself. I am not sure but that she will do it better than the medical staff, because she is always in closer touch with the pupils than any of the medical men can be, and she usually is a better judge of their qualifications and capacity than the medical men are; and, moreover, she has the advantage of consultation with the head nurses in the respective services, who can tell her what she doesn't know at first-hand about each pupil; and, after all, it is not the girl who happens to be able to answer a particular set of questions the best who will make the best nurse or who will be entitled to promotion, but the girl who is doing her work throughout the year, text-book work and clinical work as well. I think the form of having the faculty of the school pass on the qualifications of nurses is all right, but the real, substantial, discretionary work of passing pupils along for graduation must always reside more or less in the head of the training school and her teachers and head nurses. This also answers your third proposition.

JOHN A. HORNSBY.

LETTERS TO THE EDITOR

Entertainments in Sanatoriums.

To the Editor of THE MODERN HOSPITAL:

I have read with much interest your editorial, "A Need in Tuberculosis Hospitals," in the November issue of THE MODERN HOSPITAL, and fully indorse everything you say. You have struck the keynote of success in the application of the treatment, but unfortunately, as you are already aware, this need is usually entirely ignored, or met in such a desultory way as to be of no effect.

My experience of more than ten years entitles me, I believe, to speak with some authority on the subject, and hence I make the unqualified assertion that entertainment, amusement, and instruction are as essential in the application of the modern treatment of tuberculosis as are properly equipped buildings, food, and good nursing. This is one of the factors which I early recognized as essential, and have gradually worked out a scheme which is proving successful in my institution, which is as follows:

I give the patients lectures, illustrated and otherwise, on tuberculosis at such intervals as will make it possible for each patient who remains for the usual length of time to hear these lectures at least once. I have enough stereopticon slides on tuberculosis to cover the time usually occupied at three lectures. I also have a question box, which is opened once a week, or as often as I find it profitable, which is governed by the number of questions asked. We have a small library, and would have a larger one but for the fact that it is difficult to cater to a miscellaneous lot of people, and I find that they usually prefer to provide their own reading matter; therefore the library does not cut very much of a figure. I have a moving picture entertainment once each week, excepting in the summer time when the weather is too hot to have the patients indoors. We observe all the holidays, making each celebration as attractive as possible. At irregular intervals, and particularly in the winter time, we have special entertainments, either by local talent in the community or such as the patients may provide for themselves in the way of private theatricals, musical entertainments, etc. We also have a good piano and a high-grade victrola, with a large assortment of records, great pains being taken to provide new records as they are produced. Formerly I had an orchestra at least once a week for Sunday dinner. We find that the victrola is a most excellent substitute, costs less, and comes more nearly providing continuous entertainment.

While it is impossible to relieve the patient entirely from the tedium of the treatment by reason of being compelled to leave one's home, yet I feel quite sure that, while experience may develop better methods than those which now obtain, we are meeting the situation in this respect probably better than any other institution in the country—not because of our peculiar facilities, but because the demand is not recognized.

I am not writing this letter with a view to exploiting my own work, but simply as an indorsement of your editorial, with a view to encouraging your further efforts along this line.

J. W. PETTIT.

Miss Katherine Harper, of Easton, Pa., has been made superintendent, and Miss Thompson, of Bellfonte, Pa., assistant superintendent of the Lewistown (Pa.) Hospital.

REVIEWS *of* NEW BOOKS

A Manual of Diseases of the Nose and Throat. By Cornelius G. Coakley, M. D., Clinical Professor of Laryngology in the College of Physicians and Surgeons, Columbia University, New York. New (fifth) edition. 12mo, 615 pages, with 139 engravings and 7 colored plates. Cloth, $2.75 net. Lea & Febiger, Philadelphia and New York, 1914.

This work has long been recognized as one of the most practical and useful manuals of laryngology in the English language. It touches on the pathology, simplifies and abbreviates diagnosis, and emphasizes the prescribed and approved methods of treatment. Coakley has always been recognized as a great teacher, and his work emphasizes the teaching quality, which gives the work an added value to undergraduates and junior students and to those clinicians who have not paid especial attention to the diseases of the air passages.

The Practitioner's Visiting List for 1915. Four styles—weekly, monthly, perpetual, sixty-patient. Pocket size. Substantially bound in leather, with flap, pocket, etc. $1.25 net. Lea & Febiger, Philadelphia and New York.

The 1915 Practitioner's Visiting List is like its predecessors—always an advance. It is not only a visiting list, with blanks for names and dates and results, as well as for charges and financial operations by days, weeks, and months, but it is as well an encyclopedia of important things. Among the most interesting features is a therapeutic reminder, with dosage, and approved methods of treatment for the various classes of diseases. There is, in addition, a dose table of the principal preparations from the pharmacopeia; there are the poisons and antidotes; methods for the resuscitation of those who have been overcome by accident, such as drowning, electrical shock, etc. One of the most convenient features is a table of signs, to be used in connection with the memorandum pages. It is a most important little book aside from the 200 pages for notes.

A Treatise on Diseases of the Nose, Throat, and Ear. By William Lincoln Ballinger, M. D., Professor of Laryngology, Rhinology, and Otology in the College of Physicians and Surgeons, Chicago. New (fourth) edition, thoroughly revised. 8vo, 1080 pages, with 536 engravings, mostly original, and 33 plates. Cloth, $5.50 net. Lea & Febiger, Philadelphia and New York, 1914.

This new edition of a most important work bears evidence of careful revision, and the inclusion of many new methods and whatever has been learned about diseases of the nose, throat, and ear in recent years. The colored plates and illustrations generally are a most important feature of this new edition. For instance, there are thirteen original colored plates to illustrate the physiological and pathological manifestation of nystagmus, and twelve drawings to illustrate the Newmann and Hinsberg labyrinth operations. Dr. Ballinger has entirely rewritten the section on functional tests of hearing; otosclerosis has been entirely revised and brought down to date; Haynes' operation on the cisterna magna is fully described, with drawings to illustrate the technic. There is a carefully prepared chapter on salvarsan and its uses in the treatment of syphilis of the brain and auditory nerve. The new volume is 100 pages larger than the previous edition, and there are many more new illustrations. Altogether it is a most important contribution.

Blood Pressure—Its Clinical Applications. By George W. Norris, A. B., M. D., Assistant Professor of Medicine in the University of Pennsylvania; Visiting Physician to the Pennsylvania Hospital; Assistant Visiting Physician to the University Hospital; Fellow of the College of Physicians of Philadelphia. 8vo, 372 pages, with 98 engravings and 1 colored plate. Cloth, $3.00 net. Lea & Febiger, Philadelphia and New York, 1914.

The importance of blood pressure in diagnosis, prognosis, and treatment is becoming more widely recognized every day, and with this recognition has come the creation of a literature devoted to this special field. Dr. Norris' work is among the latest contributions to this literature. He has presented his subject in condensed and practical form, and as definitely as the state of our present knowledge will permit. His indices and chapter headings render the work highly valuable for reference purposes, and he seems to have had the happy faculty of coordinating abstract discussion of chemical and physiological principles with clinical findings.

The science of medicine is none too well informed concerning the essence of blood pressures, especially as these pressures operate in specific diseases. Undoubtedly we are to learn very much more in the near future concerning physiological action in the blood stream and of the heart, and we are to make far greater use of departures from the normal in the diagnosis and treatment of various diseases, and Dr. Norris has helped us in these studies in a most wonderful way.

Nervous and Mental Diseases. By Joseph Darvin Nagel, M. D., Consulting Physician to the French Hospital of New York; Member New York Academy of Medicine; Honorary Member Societe Royal de Belique, etc.; Physician to St. Chrysostom's Dispensary. New (second) edition, revised and enlarged. 12mo, 293 pages, with 50 engravings and a colored plate. Cloth, $1.00 net. The Medical Epitome Series. Lea & Febiger, Philadelphia and New York, 1914.

It must have been a huge task to review the enormous literature on the various phases of nervous diseases, and how much greater task it must have been to select the true from the false and to incorporate it into a work of less than 300 pages.

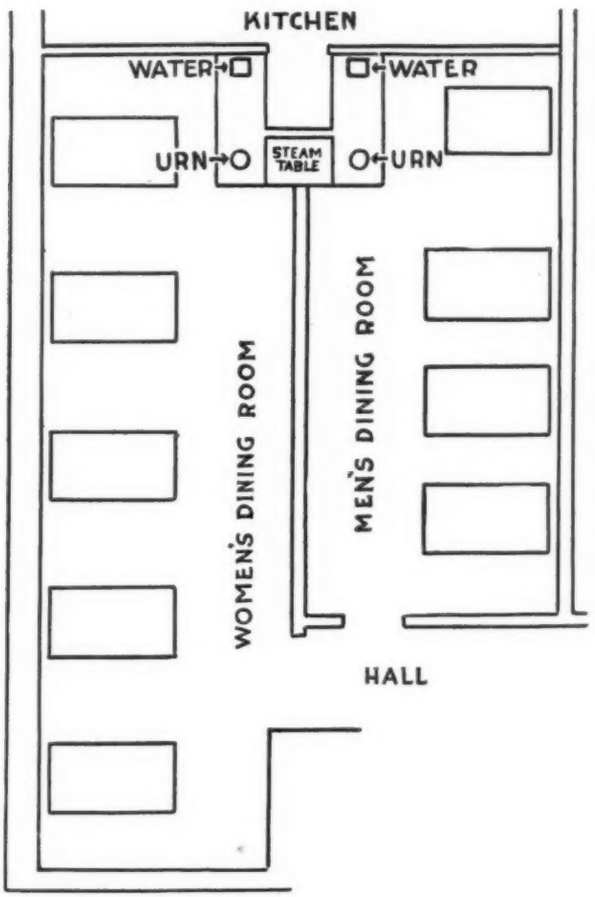
It is always refreshing for one to pick up a treatise on any medical subject and find it properly arranged, so that a great amount of time need not be spent in finding what one wants. In Nagel's work the arrangement has been almost an inspiration. He has emphasized everywhere the highlights; his definitions are simple and plain, so that a junior student may understand, and at the same time the carefulness of expression will appeal to the profoundest student of the literature, and even a greater emphasis is placed on vital parts by a series of questions at the end of each chapter, calculated to review before the reader's mind what he has gone over. There are a great many excellent illustrations and photographs and charts, a few in colors. Altogether, this epitome will save the busy practitioner an immense amount of reading and at the same time give him the very latest information on all topics concerning diseases of the nervous system and border-line cases.

THE HOSPITAL KITCHEN

Cafeteria Service in Hospitals—Rochester General Has Employed Self-Helping Method in Dining Room for Past Three Years—System Works Admirably.

BY MISS MARY L. KEITH, SUPERINTENDENT ROCHESTER GENERAL HOSPITAL.

The form of service practiced in our employees' dining rooms for the past three years is perhaps too casual to be dignified by the name of cafeteria, but, simple as it is, it works well. The two dining rooms, one for men and one for women, are adjacent to the kitchen, but not connected with it. They are separated from one another by a partition, but served from the same counter, which in



the form of a hollow square extends into both rooms. The entrance to the dining rooms is off a main hall at the opposite end (Fig. 1).

Each place at table is set; bread and butter, sugar, condiments, perhaps the dessert at noon and the sauce at night, and whatever else is to be eaten cold, is placed on the tables early, as only hot food is served over the counter, the broad side of which is occupied by a steam table. The meat is kept hot in the center compartment of the table, vegetables and soup on either side, and plates in the compartment below. The side counters, one in each room, are duplicates, with tea or coffee in an urn, with spigot, over a gas burner, and cups stacked beside it. Glasses are on shelves beside the running water.

At meal time one woman stands inside the 4-foot hollow square, and each person who enters the dining room goes to the counter, states his desire for much or little, and, while it is being put on his plate by the one server, he draws his tea, coffee, milk, or water, and then, with cup and saucer in one hand and plate in the other, goes to his place at table. Soup is served in a low bowl, and the plate set on top of it. After eating, each person stacks his empty dishes and returns them to the counter, which is only a step removed from the dish washer. This return of soiled dishes as part of the routine was adopted without a dissenting murmur, and is a feature much appreciated by the head of the department.

Waitresses eat their dinner at 11:30, other women employees at 11:50, the majority of the men at 12:00, followed by a small group at 12:30. This coming in relays makes it possible for one person to serve all, and by 1 o'clock 60 employees have eaten and gone, the tables have been cleared, and the dishes washed. Breakfast and supper are even more expeditious than dinner.

Before this system was introduced the cook and the kitchen help had their special table in the kitchen, and it was the cook and one other who objected to going to the common dining room and eating "that way," but after a little unpleasantness they yielded, and there has since been no trouble and no adverse criticism. Older employees, when asked, say they much prefer the present way.

We still have some waste of food, because we have always a few persons who demand more than they eat, but on an average they eat more and waste less than formerly. There is no saving in the amount of food consumed, but the employees look well fed, grumble less, have less sickness and better general health.

The system was adopted because, as the hospital grew and the number of employees increased, they required more service than we could afford to give, and, even with service, the dining rooms were disorderly, and food was not only wasted, but was carried from the room in considerable quantities.

Provision on a larger scale would have been made for this form of service if we could have foreseen what a success it was to be, and we have already regretted that we did not abolish ordinary tables with cloths and substitute tables with Carrara glass tops.

The Cafeteria Principle in Hospitals—Wide Selection of Foods Is Allowed—Waste Is Minimized and Service Costs Lowered.

The new General Hospital in Cincinnati is preparing for something similar to the Rochester arrangement for its help, and cafeteria on a more elaborate scale is being installed in the Cleveland City Hospital. Consequently it seems timely to discuss the question of the introduction of cafeteria service for the entire hospital staff instead of the waiter service now in general use.

As to the question whether the hospital staff would prefer the cafeteria system to the present system, one can consider it only a fair sample of the wants of the general public. Now the general public has declared most emphatically that it likes the cafeteria service. In every city

the cafeterias are daily growing in number and popularity, and large sums of money are being profitably invested in their equipment. Therefore it is reasonable to suppose that, given the same service, the hospital staff will take to cafeteria service the same as the general public has taken to it.

But to achieve this popularity, the hospital cafeteria must conform as far as practicable to the rules which have made the commercial cafeteria a success. The hospital equipment should be patterned after that of the commercial cafeteria, and its counter should contain an approximately equal variety of viands, as temptingly put before its patrons as the commercial cafeteria puts before its public.

The psychology of the success of the cafeteria is the preference of every person to see what they are offered to eat before choosing what they want. On the cafeteria counter are spread out soup, fish, meats, entrees, salads, puddings, pies, fruits, bread, rolls, biscuits, and, armed with a tray, one starts down the counter, letting one's eye roam over the viands displayed, choosing those which appeal, that day, to the taste.

Seeing what is most tempting to the appetite on that particular day, and being able to determine what one wants by sight, is the main reason why cafeteria service is popular, even though it involves self-service.

It will be found that by skillful cafeteria catering which is pleasing the eye and tempting the appetite with low-cost, dainty dishes, the general cost of feeding the staff can be reduced, and at the same time the general satisfaction of the staff with the catering will be greater because each one has chosen what he wants as far as the selection will permit.

A proper service equipment for a cafeteria should consist of a counter, which may be straight or L-shaped, as occasion demands. This counter should be all metal, and faced with white enamel and painted with white enamel inside. The feet should raise it 10 inches above the floor to allow easy cleaning.

The top of the counter should contain a steam table, with white enamel top and a bain-marie, and either a carrara glass or marble slab for pastry, etc., and an ice pan for fruits and other things requiring to be kept cold. Coffee urns should be at the back of the counter or on it at the end. A small sink should be provided, and a tray stand at one end. Along the front of the counter should be three oval-shaped brass or polished steel bars, along which the trays can be slid, and a brass railing should be placed in front of the counter to keep the people in line. Provision for ice water and tumblers should be at one or more convenient points in the room.

Naturally only the larger class of hospitals will be able

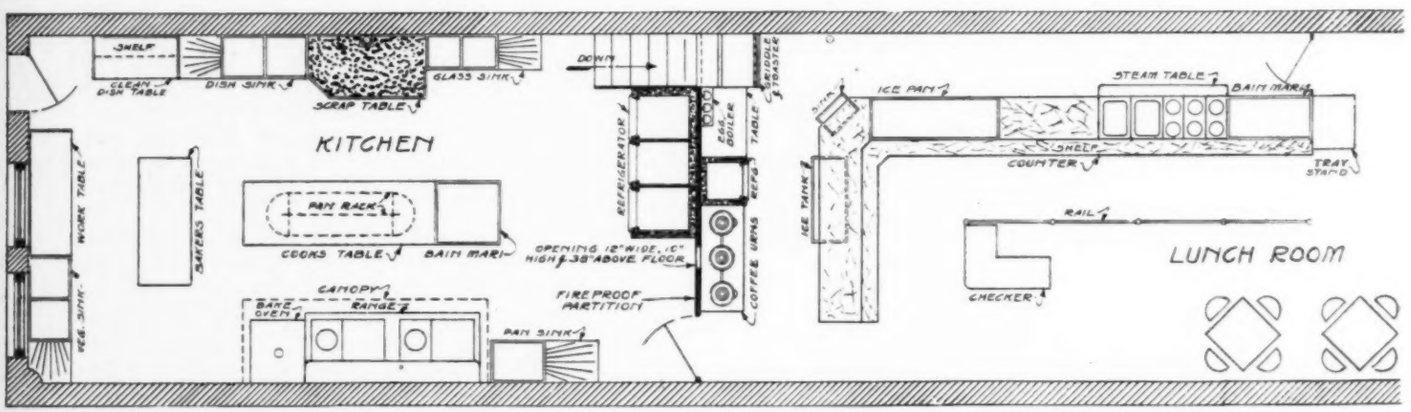


Diagram of self-serve equipment at Cincinnati, Ohio.

It is the experience of cafeteria owners that the public taste varies enormously—one tray will be filled mostly with sweet stuff, another with vegetables, spaghetti, and fruit, on all of which the profit is largest, while another will take roasts, on which the profit is small, and therefore some cafeteria owners place the sweets at the entrance end of the counter before the meats in order to have the public take the sweets and possibly eschew the meats.

These profits would be represented by savings in the hospital's expense. Employees who do not feel hungry will take light things and probably forego meat, while under the present system the meat would be brought on the table and wasted. Ladies like salads and good pies, cakes, and pastry, and it will be found that the hospital staff will, just as the general public does, choose its meal from day to day in a way that will practically do away with waste.

Tables in the dining rooms should have carrara glass tops, because they can be easily kept clean. Attendants in the staff dining rooms should be provided to take away the dishes. The household help should be made, as at Rochester, to return the empty dishes themselves, but their tables should also be glass.

to get the benefit of the cafeteria system because the system is only applicable to comparatively large numbers of people. A system such as the Rochester system will doubtless be found to work well for the household help where even only thirty or forty are employed; but for the staff, the larger the number the greater variety of food that can be provided, and the greater the success from the standpoint of giving satisfaction, and at the same time reducing expenses by the reduction of the meat bills and the waste of uneaten dishes.

A complete cafeteria equipment has been installed at the Cincinnati University, and a course of training in cafeteria work is being given students by the practical work of catering for and serving about 900 paying patrons per day. These students are working so as to make themselves eligible for cafeteria positions, and no doubt will be suitable for such positions in hospitals, especially if they have supplemented the university course by some experience in cafeterias patronized by the general public. Similar training at other universities will provide attendants of the class demanded by hospitals.

A plan for an Italian hospital has been launched in Pittsburgh.

HINTS FOR HOSPITAL SUPERINTENDENTS.

Let us begin now to think about a change in the nurses' uniforms for next summer. High, tight, stiff collars, stiff cuffs, and otherwise dress-parade harness are not conducive to whole-hearted, unselfish service. Even the soldier has a fatigue service uniform—why not the nurse, who is also a soldier?

Mr. Shilliday tells a story of an Arab sheik who, when asked the population of a town, responded, "Allah alone knows," and when he was asked about the number of deaths and the sanitation of the place replied, "It would be impious to inquire." It seems there are some Arab sheiks running hospitals in this country.

If you have rats, get rid of them. There are probably only three or four places where they can enter the premises. First go after these places and stop them—yes, you can; then set traps, set poisons, cover their holes with cement, pour dry slaked lime into their runways, starve them—fight them day and night. A rat is a disgrace to a hospital, so are cockroaches, so are mice—all of them are infection carriers—and they are unnecessary.

A noisy office and a noisy superintendent breed a noisy hospital. Grown people, like little children, play at "follow the leader." A quiet, gentle, dignified deportment on the part of the superintendent is one of the most highly communicable infections imaginable; but it is a vaccine, and everybody ought to be inoculated. I know a superintendent who goes through his institution with his hat on and a cigar in his mouth; his hospital is like an out-patient department of Bedlam.

About 75 percent of your employees would do more for you if you encouraged them and brought out their latent talents. Most people have a talent for something or other—why not experiment a little with your hospital family and develop the individual members along their most responsive lines? One of the most ingenious "handy" men I ever knew mopped the halls for two years until one day I started to fix something that developed into a rather dirty job. He was the silent man of the hospital, and I was surprised when he asked me to let him do it. That man is now master mechanic of a 500-bed hospital, and everybody has an abiding faith that there is nothing under the sun that he can't do.

Every sixty extra steps taken by a nurse is a minute wasted. Minutes run into hours, and hours run into money. It won't do to say, "Oh, well, we don't pay our pupil nurses much of anything; their service is cheap." If you don't suffer, your patients do, because they will get less attention, and attention to patients is what you and the hospital and the nurses are there for. Every inconvenience might just as well be a high fence for nurses to climb over on their way from place to place. Think of a 6-foot fence every few feet, and then compare these fences to your barriers in the shape of little time-consuming, nerve-tiring inconveniences. Better remove some of the fences.

Well-kept, white-enameled furniture inspires everybody to keep things neat in the ward; but when you enamel your furniture, give yourself plenty of time. Articles should be out of service ten days or two weeks. There is some scraping to be done and sandpapering down of the first two coats, and enamel takes time to dry. Half a dozen extra beds and a few extra pieces of other articles will allow you to go through the house gradually. Badly done furniture breeds "a lick-and-a-promise" spirit all over the house. "Like master, like man." If a bad job is good enough for the superintendent to turn out, a poor job gets to be the rule.

There is no reason why the maids and orderlies and the housemen should not be in uniform, and there is every reason why they should be. Nothing looks so slovenly in the hospital as untidy maids and men going about in all sorts of heterogeneous garb. It is impossible for these people to wear good clothes at their work, and the only alternative is to have them wear inexpensive uniforms of some sort. Good denim, or khaki, or overall stuff makes a good uniform, especially if the garments have bright buttons. Maids can at least wear long-sleeved, long-skirt aprons of some uniform figure. These uniforms will save their own clothing, and make employees look very much better and more in harmony with an otherwise clean and neat hospital.

There is a man in Buffalo, and Cleveland, and Detroit named E. M. Statler. He owns a hotel in each of the three cities, and his hotel is the best one in its city. "Well," you say, "suppose you are right; what has Statler to do with hospitals? And what is a good hotel to us?" A whole lot. Statler got out what he pleased to call a "code" awhile back. It consists of pointed paragraphs of advice to his employees, and there is more good, hard, sound sense in it that applies directly to hospitals than in any code of hospital rules ever written. "Hotel Statler is operated primarily for the benefit and convenience of its guests; without guests, there could be no Hotel Statler," begins the Statler code. This seems to be a reasonable statement, and is possessed of some of the elements of truth. Now, suppose we substitute the word "patients" for "guests"—Doesn't it pretty snugly fit hospitals? "A hotel has just one thing to sell; that one thing is service," says Statler. "A hotel that sells good service is a good hotel; a hotel that sells poor service is a poor hotel." Isn't there something about this proposition that makes it fit hospitals? "The service of a hotel is not a thing supplied by any single individual. It is not special attention to any one guest. Hotel service—that is, Hotel Statler service—means the limit of courteous, efficient attention from each particular employee to each particular guest. This is the kind of service a guest pays for when he pays us his bill—whether it is for $2 or $20 per day. It is the kind of service he is entitled to, and he need not and should not pay any more. Every guest who enters the Statler door comes in there because he believes he can buy something there better than he can buy it anywhere else. It rests with every employee of this hotel—doormen, bellboys, porters, clerks, waiters, maids, manicurists, and managers—whether he goes away disappointed or pleased." Suppose it is a free patient we are thinking about—a "pauper" if you please; somebody is paying that $2.00 per day for him, or you wouldn't keep open very long. Isn't he just as much entitled to courtesy and consideration as though he were paying it himself? Who is this hotel man, that he should have higher ideals than a hospital administrator?

Kindergarten classes at which dancing will be taught as an exercise in physical culture; a schedule of special medical lectures free to the general public, which are to be given by noted specialists who have volunteered their services; and a new department in mother and baby welfare work in the establishment of a pre-natal clinic, will be three innovations in hospital activity to be introduced in Philadelphia during the coming winter by the Children's Homeopathic Hospital.

PRESIDENT MANN ANNOUNCES COMMITTEES.

Head of the American Hospital Association Distributes Work for the Coming Year.

President William O. Mann, of the American Hospital Association, has appointed the following committees for 1914-1915:

Executive Committee—Dr. H. T. Summersgill, superintendent University of California Hospital, San Francisco, Cal.; Dr. William R. Dorr, superintendent St. Luke's Hospital, San Francisco, Cal.; Dr. R. G. Broderick, health officer, San Francisco, Cal.; Dr. Arthur A. O'Neil, superintendent Isolation Hospital, San Francisco, Cal.; Dr. Theodore Olmsted, superintendent Samuel Merritt Hospital, Oakland, Cal.; Miss A. A. Williamson, R. N., California Hospital, Los Angeles, Cal.

Membership Committee—Mr. O. H. Bartine, superintendent Hospital for Ruptured and Crippled, New York City; Mr. Howell Wright, superintendent City Hospital, Cleveland, Ohio; Dr. J. McLean Moulder, superintendent Methodist Hospital, Indianapolis, Ind.

Committee on Constitution and By-Laws and Committee on Development of the Association—Mr. Richard P. Borden, trustee Union Hospital, Fall River, Mass.; Dr. H. B. Howard, superintendent Peter Bent Brigham Hospital, Boston, Mass.; Mr. Daniel D. Test, superintendent Pennsylvania Hospital, Philadelphia, Pa.; Dr. A. B. Alexander, superintendent Winnipeg Municipal Hospital, Winnipeg, Man.; Dr. Louis B. Baldwin, superintendent University Hospital, Minneapolis, Minn.; Miss Laura E. Coleman, superintendent Homeopathic Hospital, Buffalo, N. Y.

Auditing Committee—Mr. Reuben O'Brien, superintendent Manhattan Eye, Ear, Nose, and Throat Hospital, New York City; Mr. G. W. Olson, superintendent Swedish Hospital, Minneapolis, Minn.; Dr. Arthur A. O'Neil, superintendent Isolation Hospital, San Francisco, Cal.

Nominating Committee—Dr. W. L. Babcock, superintendent Grace Hospital, Detroit, Mich.; Dr. John A. Hornsby, editor THE MODERN HOSPITAL, Tower Building, Chicago, Ill.; Dr. A. B. Ancker, superintendent City and County Hospital, St. Paul, Minn.

Committee on Hospital Efficiency, Hospital Progress, and Hospital Construction—Dr. Joseph B. Howland, assistant administrator Massachusetts General Hospital, Boston, Mass.—medical organization and education; Dr. H. M. Pollock, superintendent Norwich Hospital for the Insane, Norwich, Conn.—hospital construction; Miss Lucia Jaquith, superintendent Memorial Hospital, Worcester, Mass.—hospital finances and cost accounting; Dr. C. D. Smith, superintendent Maine General Hospital, Portland, Me.—efficiency and progress.

Committee on Noncommercial Exhibits—Miss Lydia H. Keller, St. Paul, Minn.; Miss Mary E. L. Thrasher, superintendent Robert Bent Brigham Hospital, Boston, Mass.; Miss Elizabeth F. Miller, superintendent Flushing Hospital and Dispensary, Flushing, N. Y.; Mr. G. W. Olson, superintendent Swedish Hospital, Minneapolis, Minn.; Miss A. A. Williamson, R. N., California Hospital, Los Angeles, Cal.

Committee on Out-Patient Work—Mr. Michael M. Davis, Jr., Ph. D., director Boston Dispensary, Boston, Mass.; Dr. Andrew R. Warner, acting superintendent Lakeside Hospital, Cleveland, Ohio; Dr. Joseph B. Howland, assistant administrator Massachusetts General Hospital, Boston, Mass.; Dr. Willis G. Nealley, superintendent Brooklyn Hospital, Brooklyn, N. Y.; Dr. R. B. Seem, assistant superintendent Johns Hopkins Hospital, Baltimore, Md.; Mr. G. W. Olson, superintendent Swedish Hospital, Minneapolis, Minn.; Miss Elizabeth F. Miller, superintendent Flushing Hospital, Flushing, New York.

Committee on Legislation—Dr. Wayne Smith, superintendent Harper Hospital, Detroit, Mich.; Dr. O'Hanlon, superintendent Bellevue and Allied Hospitals, New York City; Dr. H. O. Collins, superintendent City Hospital, Minneapolis, Minn.

Special Committee on the Inspection, Classification, and Standardization of Hospitals—Dr. J. A. Hornsby, editor THE MODERN HOSPITAL, Tower Building, Chicago, Ill.; Dr. Henry M. Hurd, secretary Johns Hopkins Hospital, Baltimore, Md.; Dr. Frederic A. Washburn, administrator Massachusetts General Hospital, Boston, Mass.

Committee to Consider the Grading and Classification of Nurses—Miss Charlotte A. Aikens, Trained Nurse and Hospital Review, Detroit, Mich.; Miss Emma A. Anderson, superintendent New England Baptist Hospital, Boston, Mass.; Miss Ida M. Barrett, superintendent U. B. A. Hospital, Grand Rapids, Mich.; Dr. R. W. Bruce Smith, inspector of hospitals and charities for Toronto, Ont.; Dr. William O. Mann, superintendent Massachusetts Homeopathic Hospital, Boston, Mass.; Dr. R. R. Ross, superintendent Buffalo General Hospital, Buffalo, N. Y.; Dr. Thos. Howell, superintendent New York Hospital, New York City.

Publication Committee—Dr. H. A. Boyce, superintendent Kingston General Hospital, Kingston, Ont.; Dr. J. N. E. Brown, superintendent Detroit General Hospital, Detroit, Mich.; Dr. E. H. Young, assistant superintendent Rockwood Hospital, Kingston, Ont.

Special Committee on Bureau of Hospital Information—Dr. Winford H. Smith, superintendent Johns Hopkins Hospital, Baltimore, Md.; Dr. S. S. Goldwater, commissioner of health, New York City; Dr. Henry M. Hurd, secretary Johns Hopkins Hospital, Baltimore, Md.; Dr. John O. Skinner, superintendent Columbia Hospital, Washington, D. C.

Committee to Study the Character, Cost and Value of Direct and Indirect Work for the Prevention of Diseases now Conducted by Hospitals and Dispensaries, to Arrange in the Order of Their Importance and Practicability Successive Steps for the Extension of Such Work, and to Prepare Methods for Its Financial Support and for Its Correlation with the Similar Work of Other Agencies, Public and Private—Dr. J. A. Hornsby, editor THE MODERN HOSPITAL, Tower Building, Chicago, Ill.; Dr. W. L. Babcock, superintendent Grace Hospital, Detroit, Mich.; Mr. Sidney E. Goldstein, director Free Synagogue, New York City; Miss Charlotte A. Aikens, Trained Nurse and Hospital Review, Detroit, Mich.; Mr. Michael M. Davis, Jr., Ph. D., director Boston Dispensary, Boston, Mass.

Committee to Memorialize Congress to Place Hospital Instruments on the Free List—Rev. Geo. F. Clover, superintendent St. Luke's Hospital, New York, N. Y.; Rev. A. S. Kavanagh, D. D., superintendent Methodist Episcopal Hospital, Brooklyn, N. Y.; Dr. J. N. E. Brown, superintendent Detroit General Hospital, Detroit, Mich.; Dr. W. L. Babcock, superintendent Grace Hospital, Detroit, Mich.; Dr. W. H. Smith, superintendent Johns Hopkins Hospital, Baltimore, Md.

Committee to Consider the Suggestions in Dr. Howell's Paper—Dr. Robert J. Wilson, superintendent, Health Department Hospitals Willard Parker Hospital, New York City; Dr. C. H. Young, superintendent Presbyterian Hospital, New York City; Dr. Frederick Brush, superintendent Burke Convalescent Home, New York City.

ORGANIZATION AND ASSIGNMENT OF RED CROSS WAR UNITS.

Who the Surgeons and Nurses Are and Where They Are Supposed to Be Working.

Below is given a list by units of those composing the American Red Cross relief expedition, which sailed on the "Mercy Ship" in September to assist in caring for the wounded from the battle fields of Europe. The cities from which the surgeons and nurses were enrolled are mentioned and their present location indicated according to the latest information available. In each case the surgeon first named is the medical director of the unit, and the nurse first named is the supervisor.

AT PAIGNTON, ENGLAND.

Unit D.—Surgeons: Robert W. Hinds, Medical Corps National Guard of New York, Buffalo; Fred W. Eastman, intern, Harlem Hospital, New York City; Henry M. Shaw, intern, Johns Hopkins Hospital, Baltimore. Nurses: Beatrice Bowman, Navy Nurse Corps; Virginia A. Rau, Edna Reese, Elizabeth I. Welsch, Margaret A. Strycker, Margaret Hennessey, Buffalo, N. Y.; Jessie T. Parsons, Elizabeth Weber, Adeline Thomas, Eleanor M. Scott, Minnie Mason, all of Rochester, N. Y.; Emma Evers, Connecticut.

Unit F.—Surgeons: Howard W. Beal, Worcester, Mass.; V. N. Leonard, resident surgical staff Johns Hopkins Hospital; William T. Fitzsimmons, resident surgeon Roosevelt Hospital, New York City. Nurses: Donna G. Burgar, Boston City Hospital, Margaret A. G. Hickey, Maybelle S. Welsh, Louise A. Bennett, Mary T. McCarthy, Anna Agnes Corney, Kathryn J. Ulmer, Ellen T. Riley, Anna S. Barclay, Grace K. Perkins, Frances B. Latimer, all of Boston; Nellie M. Strong, Connecticut.

Both of the English units have finally been stationed in the American Hospital in Paignton, with Dr. Beal in charge. This hospital has about 350 beds. Unit D spent some time in the Haslar Royal Naval Hospital at Gosport. It has been decided to send an additional force of two surgeons and six nurses to join the English contingent.

AT PAU, FRANCE.

Unit A.—Surgeons: Reynold M. Kirby-Smith, health officer of the University of the South, Sewanee, Tenn.; John A. C. Colston, Johns Hopkins Hospital; M. H. Todd, Johns Hopkins Hospital. Nurses: Margaret Lenmann, superintendent Philadelphia Visiting Nurse Society; Mary Graham, Anna M. Goertz, Faye L. Fulton, Florence M.

Snyder, Anna C. Lofvring, Leslie Wentzel, Agnes M. Jacobs, Mary A. Mulcahy, Mary C. McNelis, Martha L. Henderson, Emma B. Loose, all of Philadelphia.

Unit B.—Surgeons: Roades Fayerweather, Johns Hopkins Medical School; Lewis C. Spencer, assistant resident surgeon Johns Hopkins Hospital; H. C. Slack, Johns Hopkins Hospital. Nurses: Alice E. Henderson, assistant superintendent Detroit General Hospital; Mary M. Boyle, Margaret W. McGary, Florence M. Waters, Grace D. Barclay, Rebecca Watson, Sydney A. Lewis, Elizabeth W. Riffel, Helen Coney, Sara W. Crossley, Valeti Case, Martha Hartman, all of the Baltimore district.

At last reports both units assigned to France were stationed in a large hospital at Pau, a mountain resort near Bordeaux.

IN RUSSIA.

Unit C.—Surgeons: Wm. S. Magill, Medical Reserve Corps U. S. A., New York City; Philip Newton, Paul H. Zinkhan, Washington, D. C. Nurses: Lucy Minnigerode, Mary F. Farley, Frieda L. Hartman, Blanche Horner, Helen Linderman, Helen G. Northwood, Sophia V. Kiel, Rachel C. Torrence, Emogene E. Miles, Maud H. Metcalf, R. Lee Cromwell, Henrietta K. Koochlein, all of New York City.

Unit H.—Surgeons: Edward H. Egbert, Washington, D. C.; Brown S. McClintic, Peru, Ind.; Arthur M. Zinkhan, Washington, D. C. Nurses: Charlotte Burgess, assistant superintendent Illinois Training School for Nurses; Eva L. Doniat, Alice Gilborne, Alma E. Foerster, Martha M. Moritz, Mary E. Hill, Charlotte Eaton, Anne Hansen, Edwina Klee, Gertrude G. Hard, Julia S. Schneider, Mary F. Bowman, all of Chicago.

The Russian units were originally assigned to Kiev, back of the Russian army which was attacking Austrian Galicia, but up to a few days before THE MODERN HOSPITAL went to press no late information regarding the location of these units had been received at Red Cross headquarters.

Miss Helen Scott Hay, general directress of nurses, is with the units in Russia.

AT BUDA-PEST, AUSTRIA.

Unit E.—Surgeons: Charles McDonald, New York City; Russell A. Jewitt, Cleveland, Ohio; John C. Miller, Shenandoah, Pa. Nurses: Alice C. Beatle, Ava P. Mautner, Clarabel Schofield, Katherine Volk, Mollie McKenney, Margaret McGuire, Minnie Bowman, Rosina Volk, Clara P. Reynolds, Nettie Eisenhard, Grace Bentley, Katrina Hertzer, all of Cleveland.

AT VIENNA, AUSTRIA.

Unit K.—Surgeons: Carl A. Snoddy, superintendent Knoxville General Hospital, Knoxville, Tenn.; Fred G. Benton, Manhattan State Hospital, New York City; Walcott Denison, St. Louis, Mo. Nurses: Elizabeth Dooley, Jewish Hospital, Cincinnati, Ohio; Mary E. Minshall, Ella Weinmann, Lulu B. Martin, Cynthia Richardson, Anna Sutter, Margaret J. Leonard, Ella Kathleen Hoff, Anna Domershausen, Bertha M. Butterfield, Margaret Bodkin, all of Cincinnati; Genevieve Dyer, of Chicago.

AT KOSEL, GERMANY.

Unit G.—Surgeons: Bial F. Bradbury, chief surgeon National Guards of Maine, Norway, Me.; R. H. Newman, Knoxville General Hospital, Knoxville, Tenn.; John Lancer, Fordham University Clinic, New York. Nurses: Frances G. Meyer, New York Lying-In Hospital, New York City; S. Louise Stone, Hattie B. Moore, Grace Gilday, Linna K. Meirs, Margaret B. Purvis, Ellen Jane Thomas, all of New Jersey; Lillian L. Halliday, Alice B. W. Weston, Sarah A. McCarron, Esther Rosenberg, Louise E. Siegel, all of Brooklyn, N. Y.

This unit, at Kosel, in Silesia, is attached to a military hospital of 800 beds.

AT GLEIWITZ, GERMANY.

Unit I.—Surgeons: Charles H. Sanders, resident surgeon Garfield Memorial Hospital, Washington, D. C.; J. F. Spearman, Mercy Hospital, Baltimore; Grover A. C. Stem, Washington, D. C. Nurses: Anna L. Reutinger, Directress of Nurses New York Lying-In Hospital; Mary M. A. Weiss, Caroline W. Bell, Bertha M. Becht, Mary A. Brownell, Dorothea Mann, Claudia M. O'Neil, Lulu M. McEnany, all of New York City; Reba J. Taylor, Clarice Buhrman, Harriet T. Hankins, Helena A. Fitz, all of Washington, D. C.

Unit I, at Gleiwitz, Silesia, is only thirty miles from Kosel, where Unit G is located.

IN SERVIA.

Unit J.—Because of the impossibility of reaching Servia except by way of the Mediterranean, the Servian unit shipped on a Greek liner. Surgeons: Edward W. Ryan, James C. Donovan, William P. Ahern, all of New York City. Dr. Ryan spent the last two years in Mexico in connection with the work of the American and Mexican Red Cross societies. Drs. Donovan and Ahern were house surgeons at the Fordham Hospital. Nurses: Mary E. Gladwin, superintendent Akron (Ohio) Visiting Nurses' Association; Helen L. Kerrigan, Mary F. Keller, Esmee Everad, Helen L. Smith, Brooklyn, N. Y.; Anna Hirsbrunner, Agnes J. Gardner, New York; Augusta M. Condit, Nell F. Steel, Columbus, Ohio; Stella May Hall, Albany, N. Y.; Ida F. Lusk, Helen L. Latimer, New York.

Two additional units were expected to sail for Servia on the steamer Finland November 17. One of these units includes Dr. Ethan Flagg Butler, Rochester, Minn.; Dr. S. H. Hodge, Knoxville, Tenn.; Dr. James F. Donnelly, Stapleton, N. Y. With the other unit are Dr. E. P. Magruder, Glendale, Md., Drs. Clapham P. King, Morton P. Lane, Washington, D. C.

PATIENT'S DEATH DUE TO NURSES' STRIKE.

Nurses Quit in Middle of Surgical Operation—Patient Died —Is This Possible?

A special dispatch to the Cincinnati *Enquirer* and other papers, sent out on November 9, tells the following story, which is published for what it is worth, as it is inconceivable that its statements can be true without some mitigating explanation:

Orin Day Pomeroy, whose home was at College Point, and who was operated on for appendicitis at the Flushing Hospital a week ago, at the time the nurses in the hospital went on a strike, died in that institution today.

Pomeroy was on the operating table under the influence of an anesthetic, and the operation, performed by Dr. C. Story, was under way, when the three nurses assisting the operating surgeon left the room.

Dr. Story was greatly embarrassed by the desertion of the nurses, and had to call in other physicians at the hospital to do the nurses' work to permit of his completion of the operation.

Dr. Story today refused to discuss the cause of Pomeroy's death, but Dr. A. S. Ambler, who was Pomeroy's household physician, said that death had been due to malignant endocarditis, and had been induced by the desertion of the nurses.

A hotel building at Waupaca, Wis., is being fitted up as a hospital.

HOSPITAL FEES FOR INDUSTRIAL CASES.

Detroit Is First to Offer Definite Plan and Set Schedule of Fees in This Class of Cases.

Now that nearly every state in the union is enacting legislation to provide care for industrial workers, it is necessary for the hospitals to do their share to straighten out the perplexing problems incident to the hospital care of the sick who are entitled to industrial benefits of one sort or another. One of the first things to settle is the question of the hospital fees that must be paid by insurance companies and industrial employers. Massachusetts, always among the foremost to meet the needs of its people in public health matters, has had this matter under consideration for several months. It is given to Detroit, however, to announce a definite plan and fixed hospital fees in this class of cases. Under date of November 1 six hospitals of that city, acting together, promulgated the following notice, which must be of great interest everywhere:

To Employers of Labor and Insurance Companies:

The following represents a fee schedule adopted by the hospitals of Detroit as minimum fees for the board and care of industrial accident cases under the Michigan State Compensation Law. With the exception of the items for board, bed, and nursing, the fees outlined have been and are being charged by most of the hospitals of Detroit at the present time. The rate per day for board, bed, and nursing of compensation or industrial accident cases heretofore paid the hospitals of Detroit has been insufficient to cover the cost of maintenance of these patients.

The deficiency has been made up out of the income from endowment funds or voluntary contributions, which contributions are intended for the maintenance of charity or semi-charity patients.

The hospitals which are signatories to this schedule are not conducted for profit, and it is not their desire to charge any higher fees for services rendered than a figure approximating the average per capita cost. Accident or surgical cases cost the hospitals more for maintenance and care than any other class of hospital patients. It is believed that the rate of $15 per week is less than the average cost of maintenance o faccident or surgical cases, and one or more of the larger hospitals are now engaged in a system of cost accounting in order to establish accurate maintenance figures. The hospitals reserve the right to withdraw or change this schedule after due notice.

HOSPITAL FEES FOR COMPENSATION AND ACCIDENT CASES.

Bed, board, and general nursing (minimum charge $5.00), per week	$15.00
Operating room fee for each operation, large cast, etc.	5.00
X-ray examinations (including a second confirmatory examination)	10.00
Secondary surgical dressings	$1.00 to 2.00
Ambulance service, for first mile	2.00
Per additional mile	1.00
Special graduate nursing, including board of nurse, per day	4.75
Laboratory examinations (seldom needed in accident or surgical cases)	$2.00 to 10.00
Special drugs, serums, vaccines, mineral waters and liquors	at cost

HARPER HOSPITAL,
By Wayne Smith, Secretary Board of Trustees.
THE GRACE HOSPITAL,
By James H. Flinn, Secretary Board of Trustees.
ST. MARY'S HOSPITAL,
By Sister Camilla.
PROVIDENCE HOSPITAL,
By Sister M. Olympia, President.
SAMARITAN HOSPITAL,
By Wm. A. Hackett, Secretary Board of Trustees.
BOULEVARD SANITARIUM,
By H. R. Barton, Superintendent.

GERMANY'S CARE OF WOUNDED.

Special Type of Auto Car in Use on the Bloody Fields of Europe for First Aid and Transport.

The illustration shows two views of a novel type of automobile used for carrying sick or dead persons. This three-wheeled vehicle has the so-called cyclonette shape very common in Germany. It has several advantages over the usual four-wheeled motor cars or horse vehicles. The load of the engine lies over the front wheel, which thus receives sufficient pressure for adhesion. No load is carried on the rear wheels, and, as there are no gears, these are free from vibrations and noise, which for the sick person is decidedly important. The patient rests directly over the rear shaft.

The mechanism is very simple. There are no knuckles, levers, rods, or guide wheel, the steering being done as on a bicycle. Other complicated and expensive parts, such as cardan shaft or sprocket wheel, differential, water-cooling pump, spray carburetor, fan, etc., are not used, reducing the initial as well as the running expenses about one-half.

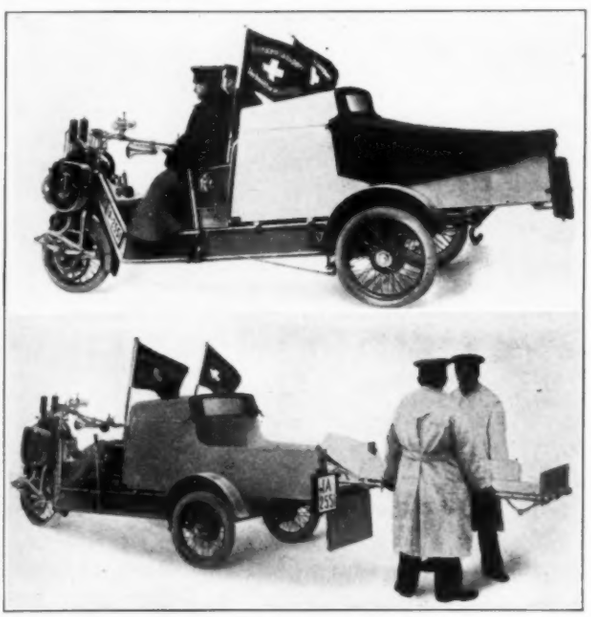


Fig. 1. German military auto car for first aid and transport. These cars are flying over all battle fields.

The engine is air-cooled by two vacuum coolers working automatically. The frame is principally of wood, with an elevated front. The back can be removed, as it is hinged, and it is easy to place the patient in and take him out of the car. The patient rests on a stretcher made of steel tubes, fitted with springs, and the head portion and both sides can be lowered or elevated. The car is approved by the Berlin League for First Aid.

The hind part is inclosed with sailcloth, which can be readily put on and taken off. At the upper part a window of flexible material is inserted, and space is allowed for the installation of a heating device. A box with the necessary appliances, bandages, etc., is always carried. The car can cover, with three persons, 50 kilometers an hour, and consumes in that time only about three liters of gasoline, which costs in Germany 1½ marks. Owing to lighter weight, the tires last longer, the car weighing, without stretcher, 350 kilograms.

The Boomerang

A FABLE WITH A MORAL

"Boomerang: A weapon which, when thrown with the intention to injure another, often rebounds and smites the thrower."

A Gentleman, wishing to purchase an Automobile, called on an Agent who was known to be a "Knocker." As the Agent saw the Gentleman drive up in a "Collapsible" Car, he shouted, "Aha, a man who uses such a Car takes Chances." The Gentleman thereupon threw in the Clutch and rode to the Second Agent. "I have been looking at the A, the B, and the C Cars," he said, "but I am still undecided." "The A, the B, and the C Cars," sneered the Agent, "why, Sir, the people who make those cars are Bandits, Thieves, and Robbers; they don't know as much about Automobiles as I have forgotten." But the Gentleman had met too many of the Genus Bragger in the course of his life, so he drove to the Establishment of the "1914 Complex." "Interested in Automobiles, Sir?" queried the Genial Agent, "then, Sir, let me show you the 'Complex' and then take you out for a Demonstration." A Smile of Gladness came over the Countenance of the Gentleman as he drew forth his well-filled Bank Roll, saying, "I'll buy your Car on the Spot; You are the only Agent who appears to have a Car worth talking about. The other Agents only know *about their Competitors' Cars.*

MORAL

When a Competitor "knocks" "CLIMAX" Sterilizers, remember the Automobile Agent.

PROMISE
VERSUS
PERFORMANCE

Comparative Tests of Sterilizers At Washington University Hospital Demonstrate

The Superiority of the "CLIMAX"

In October the authorities of the new Washington University at St. Louis made comparative tests of "CLIMAX" Sterilizers with other makes in order to decide which manufacturer was selling his goods on CLAIMS and which on FACTS. Those present were a surgeon, a hospital superintendent, an architect, a builder, and an engineer. Exhaustive and minute comparisons of the two makes of apparatus were made, so that their conclusion can be accepted as representing the true facts. The results showed

WHICH IS THE BEST STERILIZER

in the most convincing and conclusive manner.

Note some of the findings:

MATERIALS—In actual intrinsic value of the materials employed, "CLIMAX" Sterilizers were proven to be worth at least 25 percent more.

CONSTRUCTION—"CLIMAX" Sterilizers were shown to be of better design, better finish, and better suited for their purpose. The workmanship was so superior as to cause comment.

OPERATION—In convenience of operation, "CLIMAX" Sterilizers were demonstrated to be far in advance in every essential feature.

The results of these tests were no surprise to this Company, and only bore out the conclusions at which every intelligent purchaser arrives by ignoring claims and demanding facts.

RESULTS COUNT!

This Hospital purchased 34 "CLIMAX" Dressing, Water, Utensil, Instrument, and Dish Sterilizers, and we invite actual comparison of the apparatus delivered with any made—*the result will speak for itself.*

SOME NOTABLE EQUIPMENTS

BELLEVUE HOSPITAL, NEW YORK—
The largest equipment ever installed, consisting of 115 Sterilizers, all "CLIMAX."

WASHINGTON UNIVERSITY HOSPITAL, ST. LOUIS—
Equipped with 34 "CLIMAX" Sterilizers; the largest electric-heated equipment in the world.

FLOWER HOSPITAL, NEW YORK—
New building completely equipped with "CLIMAX" Sterilizers of the most approved design.

EVANSTON HOSPITAL, ILLINOIS—
Nearly $15,000 worth of "CLIMAX" Sterilizers installed, including the newest type of Dish Sterilizers for contagious hospitals.

ROCKEFELLER HOSPITAL, NEW YORK—
Entirely equipped with "CLIMAX," and pronounced by the hospital as being "perfect in operation."

SWEDISH HOSPITAL, MINNEAPOLIS—
"CLIMAX" Bed-pan Sterilizers and Washers, chosen over all others.

MT. SINAI HOSPITAL, NEW YORK—
Two of the largest Dressing Sterilizers made, in constant operation for over eleven years, demonstrate their durability.

COOK COUNTY INSTITUTIONS, CHICAGO—
Over 52 "CLIMAX" Sterilizers purchased in one year.

BRITISH FOREIGN OFFICE HOSPITALS—
25 "CLIMAX" Sterilizers in use in the Orient.

CUBA—
Nearly every hospital in the Island equipped with "CLIMAX."

U. S. HOSPITAL SHIP "SOLACE"—
Complete equipment of "CLIMAX."

THE RED CROSS SHIPS
Sailing for Europe since the war carried "CLIMAX" Sterilizers for use in Military Hospitals.

"CLIMAX"—THE STERILIZERS
With *all* of the advantages and *none* of the disadvantages of other sterilizers.

THE HOSPITAL SUPPLY CO.
55 Fifth Avenue
NEW YORK
MANUFACTURERS

THE STANDARD THROUGHOUT THE WORLD

Climax Sterilizers

THE STERILIZERS WITH ALL THE IMPROVEMENTS

CATALOGUES
covering
STERILIZERS AND FURNITURE
on request

CONTENTS

MOTT'S

HOSPITAL SANITARY APPLIANCES—HYDROTHERAPEUTIC APPARATUS AND EQUIPMENT FOR OPERATING AND STERILIZING ROOMS. AUTOMATIC HOT WATER SPECIALTIES FOR

Modern Hospitals, Sanitariums and Hotels

THE BILTMORE, New York,

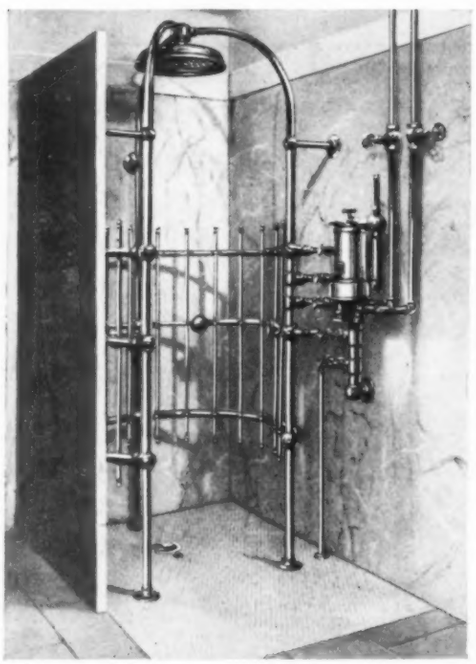
in addition to

950 Mott Bath Rooms

has the most

Modern Turkish Bath in America

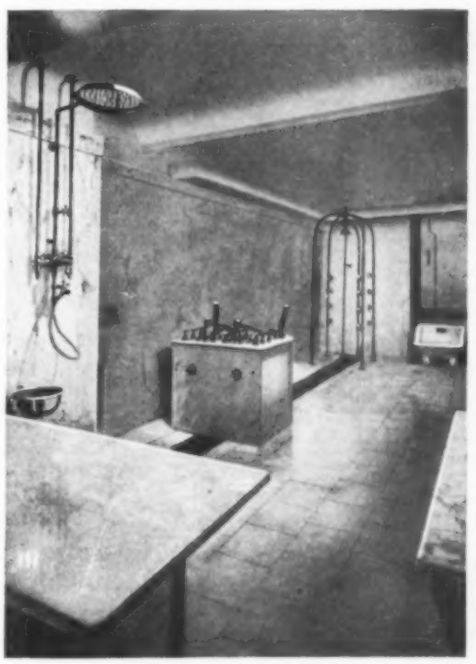
Provided with Apparatus to Supply Water at predetermined temperature and pressure to Needle, Shower and Seat Bath as illustrated. Electric Light Cabinets, Nauheim, Galvanic and Faradic Baths. Also other fixtures indicated on floor plan.



Combination Needle and Shower with Leonard Valve

Floor plan Bath Department

Write for details relative to special baths provided with Automatic Safeguard against scalding. Also description of Emergency Hospital Operating and Sterilizing Room equipment, Nineteenth Floor of Building.



Interior Hydriatic Department

Our staff of Hospital Experts and the Engineering and Designing Departments are available to give service to our customers.

The J. L. MOTT IRON WORKS

1828—Eighty-Six Years of Supremacy—1914

Fifth Avenue and 17th St., New York
Works at Trenton, N. J.

BRANCHES: Boston, Chicago, Philadelphia, Detroit, Minneapolis, Washington, St. Louis, Denver, San Francisco, Atlanta, Seattle, Portland (Ore.), Indianapolis, Pittsburgh, Cleveland, Ohio, Kansas City, Salt Lake City.

CANADA: Mott Company, Ltd. 134 Bleury Street, Montreal, Que.

INDEX TO ADVERTISEMENTS

See Pages 71, 85 and 86 for Directory of Hospital Supplies

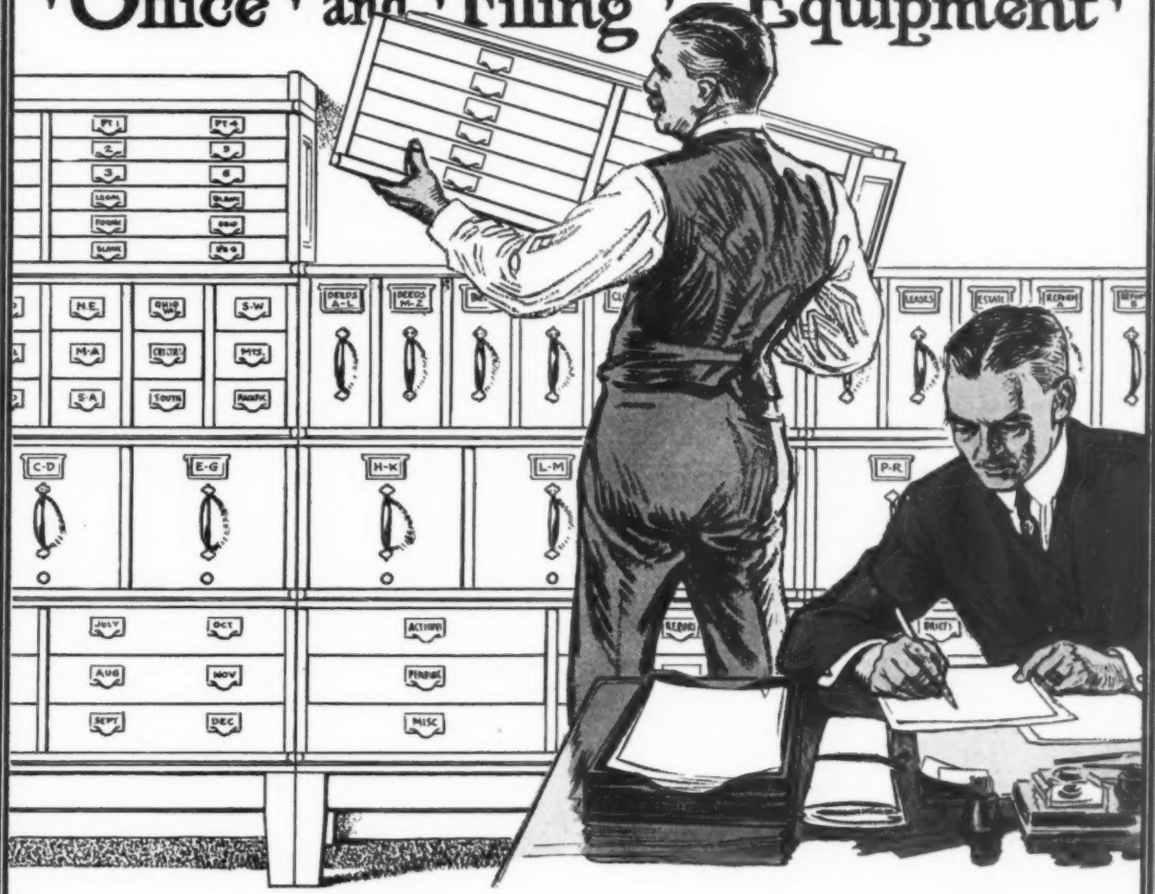
Continued on page 8.

INDEX TO ADVERTISEMENTS

Continued from page 7.

Globe-Wernicke

Office and Filing Equipment



FAR-SIGHTED hospital administrators appreciate the many practical advantages of Globe-Wernicke Filing Equipment, that make for systematic method in conducting their affairs. Globe-Wernicke files supply a constant source of storing space for filing in intelligent order rapidly accumulating hospital records and details where they can be quickly reached.

Globe-Wernicke files can be arranged and rearranged in any desired order to meet changing conditions, reorganized departments and building alterations. And the financial strength and stability of the Globe-Wernicke Company insures a permanently available supply of the standard units as future needs arise.

Globe-Wernicke Filing Equipment is made in both wood and steel, especially finished in sanitary white enamel for hospital purposes, or any other color as desired. It is the adopted standard of many of the greatest business, financial, and public service corporations and institutions today.

We also make for hospital service white enameled clip-boards for patients' charts, and record cards to meet your special requirements.

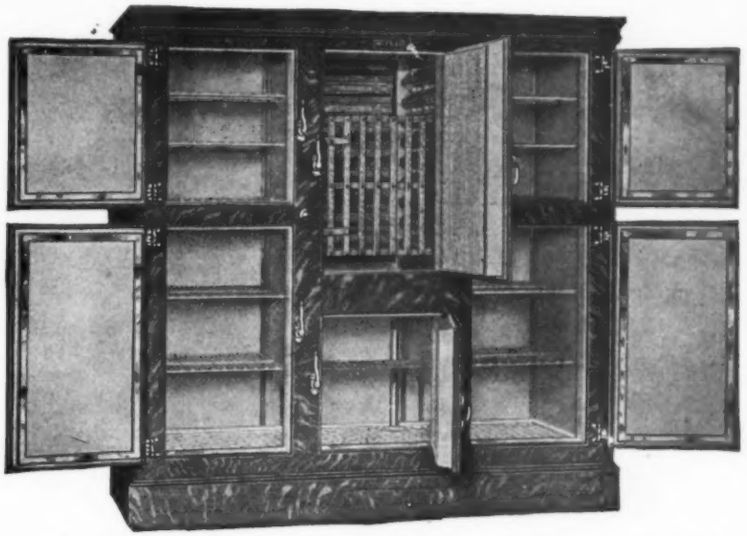
We have some valuable literature on standardization by the Globe-Wernicke way. We will gladly send it on request with Catalog UU126

The Globe-Wernicke Co.
Cincinnati

Manufacturers of Sectional Bookcases, Filing Equipment (Wood and Steel), Steel Safes, Stationers' Supplies.

On sale by 2,000 agents, everywhere. Freight prepaid.

Branch Stores: New York, Chicago, Philadelphia, Boston, Cincinnati, Washington, D. C.



For Modern Hospital Needs

the McCray Refrigerator excels. It keeps food absolutely fresh and wholesome—so vital to hospital foods where danger of infection to patients through tainted food is so great.

McCRAY Sanitary Refrigerators

after the most exhaustive investigations and exacting tests, have been adopted and are indorsed by up-to-date hospitals everywhere as the refrigerator that meets their requirements. The hospitals named below are but a few of the many prominent hospitals that are equipped with McCray Refrigerators and Coolers:

Cook County Hospital—Chicago
Jefferson Medical College—Philadelphia
St. Luke's Hospital—New York
Presbyterian Hospital—Chicago
Royal Victoria Hospital—Montreal
Rockefeller Institute—New York
University Hospital—Ann Arbor
Providence Hospital—Seattle
Lakeside Hospital—Cleveland
United States Naval Hospital—Washington

Also in use in United States Pure Food Laboratories, United States Commissaries, United States Senate Restaurants, numerous other Government Buildings Battleships, Forts, etc.

The McCray System may be arranged for either ice or mechanical refrigeration. Built-to-order Hospital equipment a specialty. Architects planning new buildings are invited to confer with our designing department for the latest developments in refrigerator construction.

Send for Catalog:

No. 50—*Hospitals and Institutions* No. 91—*Regular Sizes for Residences*
No. AH—*Built to Order for Residences*

McCRAY REFRIGERATOR COMPANY

626 LAKE STREET KENDALLVILLE, IND.

CHICAGO—158 North Wabash Ave. NEW YORK—McCray Building, 7-9 West 30th Street

Branches in all Principal Cities

Collects Dust— Does Not Scatter It

A little *Semdac* on the cloth used in the daily dusting effectually prevents that scattering and diffusion of germs that makes dry dusting such a menace.

Should be used when floors are wiped, and on all fixtures, woodwork and furniture—wherever germ-laden dust has settled. *Semdac* will gather it up, leaving the surface clean and sanitary.

With *less labor* and *better results* than can possibly be obtained with old-fashioned scrubbing.

Semdac Liquid Gloss

The Modern Labor Saver and Aid to Sanitation

The usefulness of *Semdac* does not end with general dusting and polishing. Nothing better for the cleaning of white iron beds, tables and fixtures, and for white enamel woodwork. The maintenance of the spotless hospital white will not be such a problem if you employ *Semdac*.

Brightens mirrors and windows, saving both time and effort. Keeps automobile and ambulance bodies looking like new. Has an endless range of use in garage and stable.

No institution, large or small, where perfect sanitation is imperative and labor saving a consideration, can afford to overlook *Semdac*.

For Sale Everywhere by Leading Dealers.

STANDARD OIL COMPANY

(AN INDIANA CORPORATION)

(243)

Enormous Saving in Dead Load

PYROBAR Gypsum Tile is in use in hundreds of modern buildings such as the David Whitney Building and the Statler Hotel here shown in course of erection in Detroit, Mich. Its proven efficiency as fireproofing material is backed by economical advantages—saving in dead load, saving in breakages, etc —which need only to be known in order to be accepted as decisive in favor of PYROBAR.

Comparison With Clay Tile In the Matter of Dead Load

In the Statler Hotel, photographed on the opposite page, about 600,000 square feet of PYROBAR are used. Comparison with the same amount of Hollow Clay Tile, shows the following enormous saving in dead load:

	3 in. Hollow PYROBAR	3 in. Hollow Clay
Unfinished per sq. ft.	9¼ lbs	15 lbs.
Mortar for setting	2 lbs.	4 lbs.
Plaster both sides	6 lbs.	9 lbs.
Total Weight Finished Wall	17¼ lbs.	28 lbs.

600,000x17¼=10,350,000 lbs. 600,000x28=16,800,000 lbs.
Saved in dead load, 6,450,000 lbs., or 3,225 tons.

A PYROBAR Partition Is 60% More Sound Proof Than a Clay Tile Partition

As fireproofing material, PYROBAR has the approval of the National Board of Underwriters. Its sound-deadening quality has been tested by the Lewis Institute of Chicago, and its superiority over Clay Tile in preventing sound from penetrating from room to room, has been definitely ascertained to amount to 60%.

In the Hospital the demand for protection against fire is paramount. That demand is best answered by PYROBAR. The facts will be gladly sent to anyone requesting them. Ask for Booklet J.

GYPSUM COMPANY

205 West Monroe Street, CHICAGO

KANSAS CITY SAN FRANCISCO

What a Hospital Superintendent Says

about the

Leonard Water Temperature Control Valve

The following letter, recently received from the superintendent of a prominent hospital, clearly indicates the efficiency of the Leonard Valve:

> **"I have had the valve recently ordered by us placed on one of the continuous bath tubs in the Women's Department, and assure you that it has worked splendidly—in fact, beyond my expectations. I have taken up the matter with our architect, and, as we are renovating a new wing and have four continuous bath tubs specified, I have given instructions that each tub be fitted with one of your small valves. Our architect has been favorably impressed with what I have told him about the efficiency of the valve and by what he has seen of the valve in actual use.**
>
> **"We have been trying one case continuously, and have been very successful because we were able to keep the temperature of the water at the desired point, *and as a result we have been able to handle this patient where before it was impossible to do anything for her by the continuous bath method.* It is a source of relief to feel that a patient can be treated in this manner with safety."**

Correct Hydrotherapeutic Treatment Cannot Be Given With the Old Devices

Hydrotherapeutic treatment simply cannot be properly given with the old take-a-chance faucet or ordinary "mixer" regulating process. Water temperatures ***must be predetermined, immediately secured,*** and ***maintained.*** The constant vigilance of bath attendants, and all sorts of human-element hazards must be done away with. We can safely guess your present skepticism. We have received many letters of the "We-have-been-fooled-so-many-times" and "No-mixer-we-ever-saw-amounted-to-anything" variety, and state that these individuals and institutions have been convinced and are now enthusiastic regarding our valve.

One-third Size

The Leonard Valve Will Be Sent on Trial

We are perfectly willing to ship one of these valves for trial purposes, so that you may study its efficiency. With the ***Leonard Valve*** you know that your prescription of a bath at a certain temperature will be as accurately filled as any prescription calling for the compounding of medicine.

LEONARD-ROOKE COMPANY

PROVIDENCE, R. I.

Mattcote your Walls—

Make them Beautiful, Sanitary, and Washable

The Standard Washable Dull Finish Oil Paint

MATTCOTE FOR HOSPITALS is an oil paint for interior walls and woodwork of hospitals that meets every requirement for hospital interiors.

The soft, dull tone is pleasing in appearance and beneficial in effect. It is made in a variety of beautiful, standard hospital shades that produce many harmonious and artistic color effects.

MATTCOTE FOR HOSPITALS dries with a hard, non-porous surface that can be washed frequently without affecting the surface or color. The smoothness of the finish prevents the dust and dirt from adhering to the walls and permits them to be readily wiped clean.

MATTCOTE FOR HOSPITALS is a permanent non-fading finish, and it is economical because of its extreme durability.

FREE TRIAL QUANTITY SENT TO HOSPITALS

Write for interesting literature and color card.

WHITE ROCK HOSPITAL ENAMEL meets the special requirements for hospital interiors. Equal to imported enamels.

A PARTIAL LIST OF USERS.

Mercy Hospital, Des Moines, Ia.
Madison General Hospital, Madison, Wis.
Youngstown Hospital Association, Youngstown, O.
St. Mary's Hospital, Milwaukee, Wis.
Trinity Hospital, Milwaukee, Wis.
Mt. Sinai Hospital, Milwaukee, Wis.
Waldheim Park Sanatorium, Oconomowoc, Wis.
St. Vincent's Hospital, Green Bay, Wis.
Hospital for Criminal Insane, Waupun, Wis.
Milwaukee County Hospital and County Buildings.
State Tuberculosis Sanitarium, Wales, Wis.

PATEK BROTHERS, Sole Makers **MILWAUKEE, WISCONSIN**

Warm Ether Apparatus

(Caine)

CONVENIENT—SAFE—RAPID—INEXPENSIVE

Delivers a Uniformly Regulated Warm Flow of Vaporized Ether

Produces quiet anesthesia rapidly. Entire absence of cyanosis. Operated by foot pump, leaving the hands of the anesthetist free for manipulation and to assist the operator.

Preferred method of anesthesia in oropharyngeal surgery, as the mouth-piece hangs in the corner of the mouth, retracts the cheek, draws the chin forward, and the face is not covered.

The *practical method* for GENERAL WORK with the addition of a Gwathmey mask. Every hospital should have the complete outfit.

Decreases Dangers of Overdosage—Minimizes Deleterious After-effects

Nothing about the *Caine Apparatus* to get out of order. Simple in construction and inexpensive to operate. Wearable parts easily replaced at slight cost. It effects a saving in ether of one-fourth to one-third. Always ready for immediate use.

Illustrative descriptive circular on request

The McDermott Surgical Instrument Co., Ltd.

Sole Licensed Manufacturers

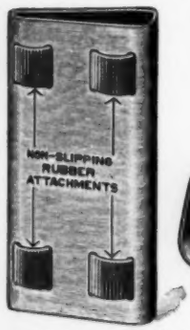
734-738 Poydras Street **New Orleans, La.**

Two New Nursing Appliances

A Sample of either, or both, of these Appliances will be sent on Approval to any Hospital in the U. S. Try for Twenty-Four Hours, and if not satisfactory return at our Expense

Non-Slipping Knee and Thigh Support and Foot Brace

Keeps the Patient from Sliding Down in Bed



Bottom View, Showing Non-Slipping Attachments

A Comfort-Giving Appliance Needed in Every Hospital

Patent Applied For

Supports and Rests the Knees
Fowler Position Obtained When Used with Back-Rest
Makes a Comfortable Head-Rest

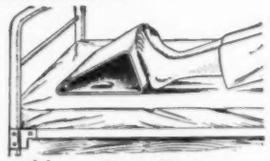
Bed-ridden Patients invariably slip towards the foot of the bed, and lifting a patient up again means quite a little laborious work for the Nurse. The Meinecke Knee and Thigh Support prevents a Patient from slipping down.

The illustrations on the opposite side show the many uses to which this Appliance can be put.

The Rubber Attachments on the bottom, which prevent the Knee Support from sliding on the bed, are corrugated and are detachable. The Support itself is made of light-colored, fine quality Veneered Wood, and is varnished all over with Valspar Waterproof Varnish.

Illustrations Showing How The Non-Slipping Knee Support is Used

No. 1—As a Knee Rest and Thigh Support — Prevents the Patient from sliding down in Bed. Gives a more comfortable position by flexing the knees, thus relieving all strain from the Spine and Abdominal Muscles. This makes it especially valuable after childbirth.



No. 2—As a Foot Brace— Prevents the Patient from sliding down. Also useful as a brace for the Feet when a Patient is eating, especially if he is holding the Tray on his lap.

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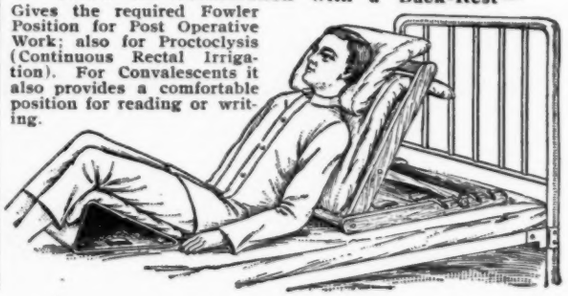

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NEWS *of the* HOSPITALS *and* SANATORIUMS

The establishment of a hospital at Newport, Tenn., is being agitated by citizens.

Work has been begun on an addition to the King's Daughters' Hospital, Staunton, Va.

Plans are being prepared for a new wing for the San Francisco City Hospital to cost $500,000.

A movement toward the establishment of a hospital for inebriates is under way at Rochester, N. Y.

The Massachusetts General Hospital is to receive $100,000 from the estate of the late Caroline L. French.

Social service work has been instituted at the Minneapolis City Hospital, with Miss Emily Sykes in charge.

Three big wards, accommodating 100 patients, have recently been added to the Presbyterian Hospital at Pittsburgh, Pa.

The new $100,000 hospital built at Clovis, N. M., for the employees of the Santa Fe Railroad, was opened in October.

R. H. Crozier, capitalist, of Upland, Pa., who died six weeks ago, left $200,000 for the founding of a hospital at Chester, Pa.

Under the terms of the will of August G. Cock, who died early in the fall, Nassau Hospital, Mineola, N. Y., will receive $80,000.

A special department for the treatment and care of communicable diseases has been opened at the Rochester (N. Y.) General Hospital.

Miss O. E. Weldon, a graduate of a Toronto (Can.) hospital, has been elected superintendent of the Nichols Hospital at Battle Creek, Mich.

Miss Nora Huyett, formerly of the Homeopathic Hospital at Reading, Pa., has been made superintendent of the new Pottsville (Pa.) Hospital.

Joseph J. Gentry, formerly a lawyer of Spartanburg, S. C., has been elected superintendent of the South Carolina Baptist Hospital at Columbia.

A county tuberculosis hospital, with a capacity of over 100 patients, has lately been opened at Ancora, N. J. Dr. L. E. Hammett is the superintendent.

Miss Lizzie Goetcher has resigned her position as supervisor of the North Texas Hospital for the Insane at Terrell after twenty-seven years of service.

Dr. Chas. P. Frischbrier, of Brooklyn, N. Y., is superintendent of the new county tuberculosis hospital opened at Saratoga Springs, N. Y., in October.

Dr. S. S. Hill, head of the Wernersville (Pa.) State Hospital, was recently elected president of the association of state hospital superintendents of Pennsylvania.

It has been announced that an experimental station to cost $45,000 will be erected near Washington, D. C., next spring for the National Vaccine Antitoxin Institution.

Dr. H. W. Roth, superintendent of the Passavant Hospital, Greenville, Pa., recently announced a bequest of $70,000 from a Chicago Lutheran whose name is withheld.

The main building of the Winyah Sanitarium at Asheville, N. C., founded fourteen years ago by Dr. Karl Von Ruck for the treatment of tuberculosis, was recently burned. The patients, numbering 100, were removed without injury. It is estimated that the damage, which was

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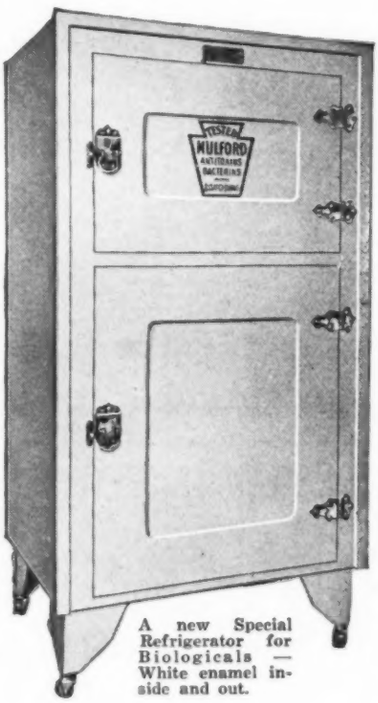

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Antitoxin kept 1 year at room temperature **lost** 16.4 percent.

Antitoxin kept 1 year at 5° C. (41° F.)—refrigerator temperature—**lost only** 8.8 percent.

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Interior drawers enable stock to be properly classified, and give quick and accurate service.

Extensive studies with Smallpox Vaccine by Dr. W. F. Elgin (Md. Med. Jour., February, 1907) show that:

Vaccine kept at 140° F. **was killed in 5 minutes.**
Vaccine kept at 98° F. (about pocket temperature) **was killed in 3 days.**
Vaccine kept at 70° F. **was weakened in 1 to 3 weeks, but not killed.**
Vaccine kept at 50° F. (about refrigerator temperature) **was active for 3 to 6 months.**
Vaccine kept at 10° F. **was active for 4 years.**

These figures clearly show the importance of keeping Antitoxins and Vaccines in a cool place.

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partly covered by insurance, amounted to $50,000. A building to replace the one destroyed will be erected soon.

St. Luke's Hospital, the New York Hospital, and the Roosevelt Hospital, all of New York City, will each receive nearly $80,000 from the estate of the late Frank J. Ransom.

Dr. Charles Holzer, head of the Holzer Hospital, Gallipolis, Ohio, was married in October to Miss Alma E. Vornholt, formerly on the nursing staff of Grant Hospital, Columbus.

The new $100,000 home of the King's Daughters' Hospital at Norfolk, Va., is being occupied. It has a normal capacity of 80. Miss Florence E. Leslie is the superintendent.

Miss Katherine McGrath, formerly head surgical nurse of the Children's Hospital, Detroit, has been appointed supervising surgical nurse of the Grace Hospital at the same city.

The Dickinson Hospital, Northampton, Mass., is now presided over by Miss Alice C. Cleland, who was formerly superintendent of Dr. Millet's Sanatorium at East Bridgewater, Mass.

Mrs. L. M. Thompson has been appointed superintendent of the Union Hospital at Dallas, Tex. She succeeds Miss Jessie Barnes, who resigned early in the fall, when she was married.

It has been announced at Washington that a general reorganization of the marine hospitals and quarantine stations of the United States is soon to be undertaken by the Treasury Department.

As a result of a campaign for funds conducted last year, the Homeopathic Hospital at Reading, Pa., has been enabled to add an entire floor to its building and to erect a greatly needed maternity wing.

A company has been incorporated for the purpose of erecting a sanatorium at Lawrence, Ark. The capital stock is given as $520,000. Louis Wine Bremerman, of Chicago, is president of the corporation.

Miss Margaret Robinson, for several years superintendent of the surgical department of the Grace Hospital, Detroit, Mich., has been appointed superintendent of the Burlington Hospital, Burlington, Iowa.

Early in October fire partially destroyed the Winyah Sanatorium at Asheville, N. C. The patients were removed without casualty, and the burned building will be at once replaced with a new and larger structure.

Miss Helen Winter, of Topeka, has been appointed superintendent of the Cushing Hospital at Leavenworth, Kan., to succeed Miss Hanna, the latter having accepted a position in one of the hospitals at Atchison.

Applications for admission to the new state tuberculosis hospital opened at Norton, Kan., in November greatly exceeded the starting capacity of the institution. Several additional cottages will be built during 1915.

A campaign to raise $100,000 for St. Francis Hospital, Jersey City, N. J., on the occasion of its golden jubilee was started the last week in October. It was expected that the money would be raised by Thanksgiving.

Builders are estimating on plans for a one-story addition, 30x40 feet, to the accident ward of the Methodist Episcopal Hospital, Philadelphia. The structure is to be of brick and terra cotta, and will cost about $6,000.

A dental clinic has been established in St. Barnabas Hospital, Minneapolis, by the Hennepin County Juvenile Protective League, an organization devoted to looking after the physical welfare of the city's poor children.

The King's Daughters' Hospital at Columbia, Tenn., recently announced that donations of canned fruit and preserves would be appreciated. More than 150 ladies responded, each promising to give at least half a gallon.

Milwaukee's new $100,000 radium hospital is in operation. It is located at 573 Cass street, in a red stone structure purchased by the corporation. Thirty beds have been provided. The hospital is in charge of Dr. O. A. Strauss.

Miss Clara B. Pound, a graduate of the Grace Hospital (Detroit, Mich.) training school for nurses, has been ap-

pointed superintendent of the Reid Memorial Hospital, Richmond, Ind., and assumes her new position January 1, 1915.

General Villa's army in Mexico has a portable ice plant made in York, Pa., and assembled at El Paso. The outfit was designed for humanitarian purposes, and is in the same class as similar machines used by the Red Cross societies.

The Kenosha (Wis.) Hospital is now presided over by Miss Harriet Jean Robinson, formerly superintendent of the Woman's Hospital, Chicago. Miss Robinson succeeds Mrs. Helen de Spelder Moore, who will take an extended vacation.

The City Council of Philadelphia has appropriated $272,000 to the department of health for the improvement of the Contagious Diseases Hospital, the completion of the Byberry Farms, and the House of Correction at Holmesburg.

Miss Anna Belle Hays, assistant superintendent of the training school of the Minneapolis City Hospital became superintendent of the Red Wing (Minn.) Hospital on November 1, filling a vacancy caused by the resignation of Miss Julia White.

At Logansport, Ind., A. G. Jenkins, executor of the David D. Dykeman estate, has received plans for the Mary Dykeman Hospital, which, under the will, he has been instructed to build at a cost of $50,000 to $100,000 and present to the city.

The $125,000 addition recently completed for St. Mary's Hospital, Green Bay, Wis., increases the capacity of the institution to 150 patients. One of the advantages of the new structure is that it provides greater comfort for the nurses in training.

A large wing, which will provide more room for patients and increase the facilities of the institution in other ways is being added to the Delaware Hospital, Wilmington, Del. Among the improvements is the installation of a new heating plant.

It is expected that the $300,000 emergency hospital being erected at Washington, D. C., will be ready for occupancy by February 1, 1915. It will consist of ten stories and basement, built of gray brick and elaborately trimmed with Indiana limestone.

According to Dr. F. W. Hatch, general superintendent of the California state asylum, the next Legislature of that state will be asked to provide funds for the erection of a separate hospital in which inebriates and confirmed drug fiends can be treated.

Miss Luella Bristol has resigned the superintendency of the Eleanor Moore Hospital at Boone, Iowa, with the view of taking up some line of public health work. Miss Bristol will be succeeded at the Eleanor Moore Hospital by Miss Kelley, from Chicago.

Miss Frances Bescherer, the newly appointed superintendent of the Homestead (Pa.) Hospital, assumed her duties October 1. She succeeds Miss Ora Woodland, who resigned to be married. Miss Bescherer is a graduate of the Philadelphia General Hospital.

Dr. Albert C. Thomas, of New Haven, Conn., for ten years head of the Connecticut State Hospital at Middletown, and at present superintendent of the New Haven Hospital, has been appointed superintendent of the Foxboro State Hospital at Foxboro, Mass.

Plans have been filed for a six-story and basement building for the Woman's Hospital, New York City. The structure is to be erected in One Hundred and Ninth street, near Amsterdam avenue, and will be known as the Thompson Pathological Building. The cost is estimated at $100,000.

Miss Eva McAuliffe was recently made superintendent of the county hospital at Jacksonville, Fla., to succeed her sister, Miss Mary L. McAuliffe, who is recuperating from a serious illness due to a nervous breakdown. The latter Miss McAuliffe is one of the most widely known nurses of Florida. She has been advised by her physicians to take a long and complete rest.

Miss Grace McElderry, of Davenport, Ia., has been elected superintendent of Hackley Hospital, Muskegon,

Mich., succeeding Miss Elizabeth Greener, who recently accepted the position of superintendent of nurses at Mount Sinai Hospital, New York City.

Reports received by the West Virginia State Board of Control from the various state penal, corrective, and insane institutions show a big falling off recently in the number of inmates, and Prohibitionists are pointing to this as an evidence of the effect of prohibition.

The vacancy in the Alliance (Ohio) City Hospital caused by the resignation of Miss Sarah Franklin, the superintendent, has been filled by the appointment of Miss Frances Trautman, who for the last three years has been employed in the City Hospital at Warren, Ohio.

Hugo Reisinger, of New York, art collector and son-in-law of the late Adolphus Busch, the St. Louis Brewer, in his will filed October 29 bequeathed $1,000,000 for the establishment and maintenance of a hospital for poor children in Wiesbaden, Germany, his native town.

Dr. J. V. Bonnette's new sanatorium at Alexandria, La., was destroyed by fire November 9. The building had just been completed and fitted up. Including furniture and fixtures, the sanatorium was valued at $20,000. It was insured for $8,250. The origin of the fire is unknown.

The Middletown (N. Y.) State Homeopathic Hospital has purchased a carload of young cattle with a view to building up a dairy. Until a year ago, when a large tract of pasture land was acquired, this institution did not have ground that could be devoted to the dairying industry.

James P. Jefferson, of Warren, Pa., has offered the Warren Emergency Hospital a complete maternity ward in memory of his wife, who was recently killed by a train. The construction work will be undertaken this winter. It is planned to spend $30,000 on the building and equipment.

Miss Harriet Leck, for seven years superintendent of nurses at the Kansas City General Hospital, has been appointed superintendent of nurses at the Grace Hospital, Detroit, Mich., vice Miss C. P. Van der Water, resigned. Miss Leck will assume her new position December 1, 1914.

Dr. Augustus L. Marshall has resigned from the superintendency of Protestant Deaconess Hospital, Indianapolis, Ind., to resume private practice, specializing in diseases of the eye. Arthur E. Guedel, M. D., of the same city, has assumed charge of the hospital as medical superintendent.

In a recent appeal to the American Red Cross, through the American Minister at Pekin, for relief for the drouth and famine sufferers in central China, Shanghai merchants declared that the loss of life and suffering has not been so great at any other time within the last twenty years.

Mrs. Alma Revelle O'Keefe, R. N., of Wichita, was reelected president of the Kansas State Nurses' Association at the annual convention held at Wichita in October. Miss Alma Murphy, of Hutchinson, was elected secretary. The next meeting will be held in Kansas City in October, 1915.

Miss Ellen M. Crowley, a graduate of the Memorial Hospital, Worcester, Mass., and a post-graduate of the Grace Hospital (Detroit, Mich.) course in hospital economics, administration, and institutional nursing, has been appointed assistant superintendent of the Sparrow Hospital, Lansing, Mich.

Illustrating the need of greater quantities of hospital supplies at the battle front in Europe, Thomas Whittemore, of Boston, declared in a message from London to the American Red Cross on November 4 that operations were being performed without ether. There were "acres" of wounded, he said.

Miss Menia Tye, superintendent of Sparks Memorial Hospital at Fort Smith, was elected president of the Arkansas State Nurses' Association at the annual session held at Fort Smith the last week in October. Miss Bella McKnight, superintendent of the Davis Hospital at Pine Bluff, was elected corresponding secretary; Miss Ruth Riley, superintendent of the City Hospital, Fayetteville, first vice-president; Mrs. W. C. Green, of Little Rock, treasurer. Pine Bluff was named as the meeting place for next year.

Sister Mary Agnes, who has directed the internal affairs of Charity Hospital, New Orleans, for five years, has

left that institution to head the sisters at the Louisiana Retreat in the same city. Sister Stanislaus, for twenty years connected with Charity Hospital, has been promoted to the superintendency.

At a recent meeting of the Board of Directors of the Philadelphia Baby Hospital it was decided to close the institution until May 1, when the work among infants will be resumed. Lack of sufficient funds is said to be the cause of the temporary closing. The dispensary at 619 Addison street will remain open.

Miss Emma Donnenwirth, a graduate of the Akron (Ohio) City Hospital, and at present a supervising nurse in that institution, is to be superintendent of the new People's Hospital at Akron. The building for the new hospital is nearing completion, and will probably be equipped and made ready to receive patients by February 1.

The Children's Hospital of Philadelphia has secured for its director of nurses, Miss Anne M. Sutherland, a graduate of the Boston Children's Hospital, who has had considerable successful experience in this line of work. The hospital proposes to revise the curriculum of its school, making the course of training three years.

Under the direction of Dr. Stewart, a Glasgow physician, orderlies are leaving Glasgow for the seat of war. They scout the country in motor cars with the object of tracing and bringing in the wounded and stragglers, many of whom are isolated in villages and farms. Sir Frederick Treves inspected the party before leaving London.

A Paris residence at Oldway, Paignton, has been transformed into a wonderfully fitted-up hospital through the work of the American Women's War Committee. It contains 150 beds, an up-to-date operating theater, and x-ray and anesthetic rooms, every possible requirement being met. It is said to surpass any other hospital in the west of England. Sir William Osler is the consulting physician.

The North Atlantic States Conference on Tuberculosis held its first meeting in Philadelphia on Friday, October 16. Over 200 physicians were in attendance. Dr. Charles William White, of Pittsburgh, presided. All phases of the fight against the "white plague" were discussed at the three sessions. Plans were proposed for increasing the sale of Red Cross seals, and considerable attention was given to home care of tuberculosis patients.

Dr. A. C. Bachmeyer, superintendent of the Cincinnati Tuberculosis Sanatorium, and formerly acting superintendent of the Cincinnati General Hospital, has been made superintendent of the latter institution, succeeding Dr. Sanborn, whose resignation took effect November 1. Dr. Walter List retains his post as assistant superintendent at the General Hospital. Dr. Harry Freudenberger succeeds Dr. Bachmeyer as superintendent of the Tuberculosis Hospital.

A naval hospital training school has been opened at the training station at Newport, R. I. Courses in practical pharmacy, chemistry, and microscopy have been arranged, and the students will be instructed in first aid, litter, and stretcher drills. Cooking and mess management will be taught in connection with the commissary school at the station. The students will go from the school direct to naval hospitals for service and, later, on board the warships.

The committee of society women collecting funds for the National Red Cross in Denver are of the opinion that their work will be a stimulus rather than a check to local charity. "Giving is contagious," said a member of the committee quoted in the Denver *Post*. "When women join our endless chain to aid us in helping the Red Cross, they are forming the habit of giving. When the chain is closed, they will turn their attention to the Denver charities, which in the meantime will receive the usual support."

Dr. Montgomery E. Leary, superintendent of Iola Sanatorium, Rochester, N. Y., is named as a director of a proposed corporation for the establishment of a children's hospital in Rochester. According to the application for incorporation, the hospital is to be strictly a charitable institution. All of the directors are members of the Rochester Public Health Association, and it is proposed for the present to utilize the building of the health association, which is already equipped for the accommodation

of fourteen children, but which, under its present status cannot be used to care for children over night, as it does not bear the legal title of a hospital.

Sir William Osler, regius professor of medicine at Oxford, and, since the beginning of the war, in close touch with hospital work among the wounded in England, declared recently that if the experience of the past counts for anything, the men at the front have more to fear from the bacilli of typhoid than from bullets or bayonets. In the Boer War, according to Dr. Osler, bacilli accounted for 14,000 of the 22,000 lives lost. He recommends vaccination measures such as have proved successful in the armies of the United States.

James G. Craig, an engineer of the Panama Canal, who visited Chicago recently, told of a model farm in the Canal Zone where laborers who have been injured while at work for the Government are cared for. According to Mr. Craig, the farm was the idea of Colonel Goethals, and is now in charge of Colonel Charles Mason of the sanitary department of the Canal Zone. More than a hundred laborers, who have been crippled, operate the farm. The men raise most of the vegetables used by the Government officials, make butter, and raise chickens.

At the recent convention of the Oklahoma State Graduate Nurses' Association, held at Enid, Okla., Mrs. Idora Rose Scroggs, of Norman, was elected president of the association for the third consecutive time. Mrs. Cora Whitsell Bearly, of Oklahoma City, was elected secretary. Miss Lela Carr is to be sent as the delegate of the association to the international convention of nurses at San Francisco in 1915, and Miss Mabel Garrison, of Oklahoma City, will go as the delegate from the Oklahoma State Board of Registration. The 1915 convention of the association will be held at Shawnee.

According to a statement issued by the National Masonic Sanatorium Association, the tuberculosis hospital it proposes to establish at San Antonio, Tex., in addition to treating members of the Masonic order afflicted with tuberculosis, will carry on research work with the view of discovering a more effective method of combating the disease. Present plans contemplate buildings and equipment that will require an expenditure of $500,000. C. A. Soule, potentate of Ben-Hur Temple, Galveston, is president of the association. Dr. C. L. Milburn, a thirty-second degree Mason, of San Antonio, is the chief physician.

An active canvass for funds for a hospital to be built in the west end of Duluth, Minn., has been begun. The movement started as far back as 1903, when an organization was formed and some money collected. Rev. J. N. Nervig, pastor of Zion Norwegian Lutheran Church, is president of the association. The project is encouraged by the local physicians, and it is said that the residents of the western part of the city have been looking forward to the establishment of a hospital in their midst ever since St. Mary's Hospital was moved from Twentieth avenue and Third street to its present site, leaving this section without local hospital service.

Work has been begun at the Josiah B. Thomas Hospital, Peabody, Mass., on a handsome new home for the nurses of that institution. The building will be 82x52 feet, consisting of basement and three stories. It will be of brick construction, with Indiana limestone trimmings, concrete foundation, slate roof, and copper gutters and conductors. In the basement will be located the boiler room, diet kitchen, and trunk room. The first floor is to have a large living room, class room, recreation room, sewing room, and a suite of three rooms for the superintendent, besides ample toilet facilities. The second floor will be arranged for sixteen nurses' rooms, sleeping porch, shower baths, bath rooms, and toilet rooms. The third floor will be finished as one large room, with possibilities for future utility. North Carolina pine will be used throughout the interior for finishing. The floors, with the exception of the main entrance, vestibule, corridor, and bath rooms, will be of hard pine, and the exceptions named will be of composition, with sanitary cove bases. The interior doors will be of birch. The home will be heated by steam, lighted by electricity, and will have an intercommunicating telephone, and also a vacuum cleaning system. The contract price is $75,000.

The Polyclinic Hospital at Harrisburg, Pa., which came into existence about four years ago and has been leading

a rather precarious existence, its growth being hindered by lack of facilities and funds, has recently purchased an excellent site on Front street, facing the Susquehanna river, on which is a large residence of more than twenty rooms admirably suited, with few alterations, for hospital purposes. Twenty-one beds are now provided, and these are practically in use constantly. The board of trustees is planning to raise funds in a short-term campaign early in the new year in the hope of clearing off an indebtedness and possibly providing a partial endowment.

Ten new city nurses, whose salaries until January 1 were provided for by a transfer of $1,500 from funds previously appropriated to the Department of Public Health and Charities of Philadelphia, will begin work on November 1 for the department's division of child hygiene. The efficiency of the division will be more than doubled by the addition of the ten nurses. For several years the division has done all its work in the congested districts with a staff of eight, who were able to do the work in only six wards of the city. With eighteen nurses the city will begin to exercise a constant and practical supervision over the health of the children in at least a dozen wards.

Steps have been taken by the Michigan state board of regulation of nurses to establish a standard curriculum in all hospital training schools for nurses. Many of the schools comply with the standard now. The board has no power to force the curriculum, but will strongly urge its adoption. The standard curriculum requires three years' training for the nurses. The state law requires only two. The board will also urge that all hospitals meet the general standard of requirements as to equipment, etc., established by the board. The board has no power over them other than it can refuse to credit their nurses when they apply for permission to take the state examination.

Four patients of the Athens (Ohio) State Hospital recently were found dead in a silo on the hospital farm. It is supposed that the men were killed by inhaling gases which had developed in the silo during the night. As a result of the accident, Ohio state officials are making a study of silo gases to ascertain their action. Experiments made with gas taken from the silo where the bodies were found revealed that it was fatal to guinea pigs and rabbits, though dogs recovered. Owing to the fact that the silo is now in common use in most of the corn-growing states, the investigations are of interest both to the medical profession and to those engaged in agriculture.

The Boston University School of Medicine has received a gift of $100,000 with which to build a maternity hospital. The name of the donor has not been made public. The gift will enable the university to carry out plans which have been progressing for twenty years. A foundation has already been laid and a one-story building erected. To this structure, which has been used as a dispensary, three and possibly four stories will be added. The hospital will be under the control of the trustees of the Massachusetts Homeopathic Hospital, but by a working arrangement with the trustees of Boston University the medical staff of the hospital is largely made up of members of the faculty of the Boston University School of Medicine.

Rev. Louis F. Ruf, a Cleveland (Ohio) pastor, in a recent sermon expressed views quite the opposite of those held by most people respecting the appeal of the American Red Cross for funds to carry on its work on the battle fields of Europe. Rev. Ruf's theory, according to the local press, is that, inasmuch as the war will probably continue as long as the money holds out, Americans contributing to the Red Cross fund are thereby prolonging the conflict. He urges that all hospital costs should be borne by the nations at war, asserting that if this were the case they would have less money to spend toward the destruction of one another. As to the human side of the Red Cross charities, Mr. Ruf says that real humanity demands that the nations cease making sufferers, and that the sooner men realize that they are mere cannon fodder, the sooner the world-wide revolt against war will begin. He is of the opinion that the people of this country ought to help, but that their charities should be extended to the widows, orphans, and aged deprived of their natural protectors. The answers of those who differ with the Cleveland pastor are, in substance, that, while there is some food for thought in his attitude, after the war has reached its present stage is the wrong time to try out the plan.

CLASSIFIED ADVERTISING.

Under proper headings this column will present advertisements of Positions Wanted, Help Wanted, Articles for Sale, etc.

When requested, replies will be received at the business office of THE MODERN HOSPITAL, Metropolitan Building, St. Louis, and will be forwarded promptly to the advertiser.

The charge is $1.00 for 30 words or less, and 3 cents for each additional word. For the convenience of both advertisers and publishers, classified advertisements are payable in advance.

POSITIONS WANTED.

POSITION—A registered nurse, experienced teacher and disciplinarian, now superintendent of nurses and assistant superintendent in 60-bed hospital, wishes to change after January 1; North or Middle West, Ohio preferred. Address M. E., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—As superintendent of small hospital or assistant superintendent in large hospital; East preferred; am graduate of large general hospital, post-graduate of Massachusetts General Hospital; R. N. of experience; at present employed. Address Linde L., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—By graduate registered nurse, position as surgical nurse; thorough experience; can furnish recommendations from present position and others. Address E. M. S., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—By graduate nurse as assistant superintendent or night supervisor; good training; best of references. Address W. X., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—By a New York state registered and graduate nurse, with twelve years' experience in hospital and training school management, position as principal of nurse training school. Address M. A. W., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—A graduate registered nurse would like a position as night supervisor. Address X. Y. Z., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—As superintendent of hospital or superior of operating room in a large hospital, by graduate registered nurse; experienced; excellent references. Address M. A. R., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—As superintendent by superintendent of hospital and training school; at present in position, but desiring change of location; references from trustees and staff. Address H. G. L., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—As superintendent of a private hospital or sanitarium by a graduate nurse with special training for this work. Address D. E., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—Registered nurse, with executive ability and experience, graduate of a general hospital of 250 beds, wishes position as superintendent of hospital of about 75 or 100 beds. Address M. Y., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—As superintendent (nonmedical); expert knowledge of every department of hospital administration; appointments held: General Hospital, Wolverhampton, England; Great Northern Central Hospital, London; Royal Hospital, Portsmouth, England; age, 37; married; highest credentials. Address J. S. Neil, 25 Florence avenue, New Haven, Conn.

POSITION—A graduate registered nurse, with executive ability, would like a position as superintendent or assistant superintendent of nurses. Address Experience, THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—As superintendent of small hospital or head nurse in large general hospital; best of references. Address J. M. R., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—Graduate registered nurse, with ten years' experience as superintendent, wishes a position; at present employed; could take position after March 1. Address E. A., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—A graduate registered nurse desires position in hospital or institution where executive and practical ability are required; has had excellent experience; would consider position in a children's hospital; East preferred. Address S. P., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

POSITION—Registered nurse, with executive ability, graduated 1907 from large Philadelphia Hospital, desires position as assistant superintendent, directress of nurses, or head nurse; age, 31 years; best of references. Address O. R., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

HELP WANTED.

SUPERINTENDENT—In a large general hospital in New York City, a second assistant superintendent; duties wholly executive; medical man, and one who has had executive and hospital experience preferred; must be single and between the ages of 28 and 40; apply by letter, stating references and qualifications. Address T. P. H., THE MODERN HOSPITAL, Metropolitan Building, St. Louis.

NURSES—If you wish hospital position, write for our plan; postal brings it. Hospitals, if you need nurses, write; we give free service to you. Halbur Exchange, Halbur, Iowa.

Continued on page 50.

CLASSIFIED ADVERTISING.

Continued from page 48.

HELP WANTED—Continued.

SUPERINTENDENT—Woman superintendent, to act also as principal of training school for hospital of 70 beds. Applicant must have experience and ability to control and manage entire institution. Kindly apply in writing to Arthur L. Marvin, 31 Nassau street, New York, stating experience fully with references and salary desired.

SUPERINTENDENT—The Harrisburg Hospital will elect a male superintendent in the near future; the hospital has a capacity of 125 beds, a nurses' training school, and nurses' home; candidate must furnish references. Applications may be made to Henry B. McCormick, President Board of Managers, P. O. Box 547, Harrisburg, Pa.

NURSES—Graduate nurses desiring institutional positions. We have calls for nurses from all parts of this country. If interested in hospital positions, write us today. Aznoe's Central Registry for Nurses, 3544 Grand Boulevard, Chicago.

FOR SALE.

FOR SALE—Guinea pigs for experimental purposes; all stock guaranteed; we have raisers located in every state and can supply any number promptly. Cavies Distributing Company.

MISCELLANEOUS WANTS.

SANATORIUM—I wish to incorporate or identify Waldheim Park Sanatorium, which is on an excellent paying basis and well patronized, with a first-class large hospital, making it, so to speak, the country annex to such an institution; would also sell it to first-class physician or take a partner. For particulars write to Dr. J. H. Voje, Oconomowoc, Wis.

MISCELLANEOUS.

CITY OF CLEVELAND,
DEPARTMENT OF PUBLIC WELFARE,
CITY HOSPITAL, Scranton Road.
November 16, 1914.

THE MODERN HOSPITAL PUBLISHING COMPANY,
Metropolitan Building, St. Louis, Mo.

Gentlemen:

We put an ad in THE MODERN HOSPITAL in October. We are receiving so many answers that I wish you would put in an ad, at your expense, telling the people that the positions are filled. Evidently it is wise to advertise in THE MODERN HOSPITAL.

Very truly yours,
(Signed) HOWELL WRIGHT,
Superintendent.

X-RAY MANUAL FREE.—This authoritative little book has been found to be of much value to hospital officials and to the medical profession generally. A copy will be sent complimentary on request. Address G. Cramer Dry Plate Co., St. Louis, Mo.

SAMPLE NAIL BRUSH—Have you had your sample nail brush? We want to send you one, and, if you will read our announcement on the back cover of the November number of this journal, we are sure you will want one. The lasting and sanitary qualities of our Rubberset Nail Brush make it worth your consideration for use throughout your institution. Avail yourself of our offer to send you a sample brush on request, and write us today. Rubberset Company, Newark, N. J.

PETTIJOHN'S ROLLED WHEAT preserves the bran content, which is an essential element in so far as securing bulk and nutritive value at the same time. The ash of foodstuffs, as it is called, while having no nutritive value, serves a most necessary purpose; if food were reduced to pure, unadulterated nutriment, and nothing else, we would soon die of food. Pettijohn's rolled wheat with bran comes nearer to fulfilling the natural function of the wheat than anything in its line. You can sample it for yourself. Turn to our advertisement on page 33 and you will see how to obtain a sample. Quaker Oats Company.

NO HOSPITAL OR HOME IS COMPLETE without a guaranteed Thurman Vacuum Cleaner, the only dustless and sanitary method. Let us send you one. We make seventy different styles and sizes, for every class of service—portable and stationary. Write today for special proposition. Free booklet. Thurman Vacuum Cleaner Company, Department M, Eleventh and Monroe streets, St. Louis.

SELF-PROPELLING SCRUBBING AND POLISHING MACHINE—Our "Utility" scrubbing and polishing machine has been especially designed for cleaning different kinds of floors so that they will be in a sanitary condition. It is entirely self-propelling, thus enabling women to operate it. Write us for catalogue and demonstration, and read our announcement on page 41 of this issue. Vacuna Sales Company, 225 Fifth avenue, New York.

Continued on page 52.

Protect Your Hospital From Deaths

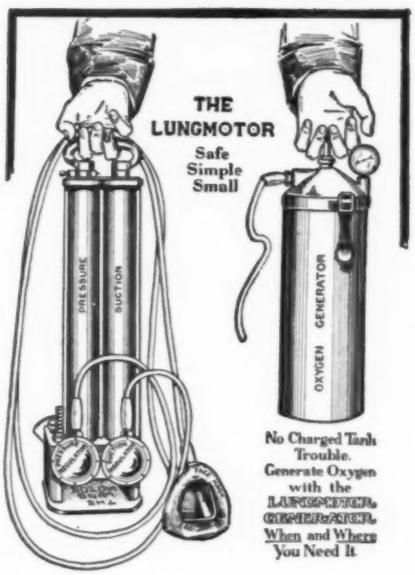
In cases of

Collapse on the Operating Table,
Asphyxia of New-born,
Narcotic Poisoning, Gas Poisoning, Etc.

By using

THE LUNGMOTOR

Here it is—small, safe, simple



HERE IS A COLLAPSE CASE:

THE PRESBYTERIAN HOSPITAL
MONTGOMERY AND SHERMAN AVENUES, PITTSBURGH, PA.

Mrs. F.; Housewife; Age, 48. Diagnosis—Obstruction due to kink in Hepatic Flexure of Colon. Operation: Breaking up of adhesions and freeing Hepatic Flexure.

Time	Temperature	Pulse	Respiration by Stethoscope	
4:20 P. M.	103⅘	130	22	On admission December 21, 1913.
8:00 P. M.	102	132	24	
10:00 P. M.	100	?	28	
11:00 P. M.	100	138	30	Patient taken to operating room.
11:11½ P. M.	100	148	30	Anesthetic commenced.
11:14½ P. M.				Surgical anesthesia, operation commenced.
11:24 P. M.	?	?	4	LUNGMOTOR, with pure oxygen, commenced, twelve strokes per minute.
11:25 P. M.	?	?	4	Operation complete.
12:00 A. M.	100	?	12	Half oxygen.
1:00 A. M.	102	160	20	Discontinued Lungmotor and gave oxygen.
2:00 A. M.	103⅘	165	36	
3:00 A. M.	103⅘	172	40	

The Lungmotor must not be considered a device for pumping air into and out of the lung—it does more than that. It reestablishes and maintains the statics of the chest, a necessary condition to successful resuscitation in border line cases. In fact, the Lungmotor is so much different in action, results, and operation from any other device, that everyone should know it—and know it now.

140 HOSPITALS equipped with from one to seven LUNGMOTORS in last few months. Buy a Lungmotor and begin saving many of those cases which have heretofore been fatal. Send for information today.

Life Saving Devices Co. MAIN OFFICE-WORKS S. E. Cor. Washington and Jefferson Streets CHICAGO, ILL.

BOSTON OFFICE—53 Devonshire Street, Room 24 NEW YORK OFFICE—1009 Times Building

CLASSIFIED ADVERTISING.

Continued from page 50.

MISCELLANEOUS—Continued.

IS YOUR INSTITUTION SO EQUIPPED that the best light is obtainable at the patient's bedside? Our Handy Light is designed to meet your requirements for an efficient bed light. The special features of our device are explained on page 52 in our advertisement. Read it and send for sample. The Handy Light Company, 2193 Handy Light Block, Cincinnati, Ohio.

COFFEE AT ITS BEST—Through the use of our Tricolator the coffee made in your institution will be 100 percent more satisfactory, more palatable, and more digestible. Our little device will work on any urn or pot. Write us for particulars and prices. The Tricolator Company, 63 East South Water street, Chicago.

ARE YOU USING OUR WIDE-MOUTHED NURSING BOTTLE in your hospital? The "Sweet Babee" bottle is made without a neck, and is easily washed on the inside like a tumbler. The nipple is made in one piece and is reversible. See illustration and description on page 54 of this issue. The Yankee Company, 170 Genesee street, Utica, N. Y.

LABORATORY APPARATUS AND REAGENTS—This is the title of our new catalogue containing 656 pages, 8x11¼ inches in size, bound in serviceable green cloth. Details of the contents of the book and how you may possess one are presented in our announcement on page 8 of this issue. Arthur H. Thomas Company, West Washington Square, Philadelphia, Pa.

WHAT IS THE CONDITION OF YOUR LAUNDRY CHUTE? Can it be maintained in a state of absolute cleanliness? We cannot tell you more than you already know about the necessity for keeping laundry chutes clean and sanitary, but we can tell you about our chute of glass enameled steel, which embodies all the qualities that recommend it especially for hospital use. Cook County Detention Hospital, Chicago, a thoroughly modern and up-to-date institution, has been equipped with the Pfaudler Chute. A catalogue showing the range of tanks enameled with glass will be furnished on request. The Pfaudler Company, Rochester, N. Y.

COMPRESSED AIR AND VACUUM MACHINE—A full description of the Robertson Tankless Compressed Air and Vacuum Machine—a machine that is simple, noiseless, and powerful—is given in our announcement on page 19 of this issue. If your institution needs one read our offer. The Jaeckh Manufacturing Company, 422 East Eighth street, Cincinnati, Ohio.

SAVE YOUR DISCARDED X-RAY PLATES—If you have any, let me know the sizes and quantities of each. On receipt of your reply I will be glad to quote you my best prices. Charles Bender, 817 Eighth avenue, Brooklyn, N. Y.

THE SCHOOL OF MEDICAL GYMNASTICS AND MASSAGE offers a practical and theoretical course in Swedish Movements, Massage, etc. Diploma. Patients secured. For further information apply School of Medical Gymnastics and Massage, 61 East 86th street, New York, N. Y.

FILING CABINETS AND SAFES—Our line of filing cabinets is the most comprehensive made. A few styles are shown on page 9 of this issue, but we will gladly send catalogue and further information on request. The Globe-Wernicke Company.

DIPLOMAS—One or a thousand. Illustrated circular mailed on request. Ames & Rollinson, 203 Broadway, New York, N. Y.

NEW CATALOGUE OF NURSES' BOOKS—Just ready. Send for a copy today. It's free. Chicago Medical Book Company, Chicago.

GENERAL SERVICE—Physicians, surgeons, and nurses furnished free for hospitals or assistants; practices of physicians, surgeons, dentists, and also of veterinarians handled and furnished in all the states; drug stores for sale; medical appliances, books, etc. (second-hand), sold and furnished; positions furnished in all the states. F. V. Kneist, Omaha, Neb.

RADIOGRAPHY—Send for our new book, "Paragon Pointers," the first practical book that has been brought out on the subject of radiography; copy will be gladly furnished on request. Geo. W. Brady & Co., 754 South Western avenue, Chicago.

THE PREFERRED HOSPITAL ANTISEPTIC—Trial quantity free. Chinosol is a more powerful antiseptic than bichloride of mercury, and it is nonpoisonous. At all times and in all places the preferred antiseptic. Try it in your institution. Sample and full literature on request. Address Parmele Pharmacal Company, 54 South John street, New York.

A WORK OF ART—A very handsome brochure has been brought out by the Bryant Electric Company, Bridgeport, Conn., and Chicago, which explains in detail and very elaborately illustrates the Bryant Silent Call Signal System for Hospitals. This brochure is a work of art, and will be gladly furnished hospital superintendents interested in an efficient signaling system. One of the features of the Bryant System is that it may be introduced into any standard electric circuit. It requires no special apparatus and has no moving or working parts to get out of order. Secure a copy of this interesting and beautiful publication.

A BETTER CUP OF TEA—Our Fairy Cup Instant Soluble Tea is made especially for invalids. It is free from tannic acid. Use it in your institution. A trial will convince you of its superiority. Just a pinch in a cup—add hot water and serve. Instantly prepared—no pot or strainer necessary. See our advertisement on page 6 of this issue and write us for fuller particulars. C. F. Blanke Tea and Coffee Company, St. Louis.

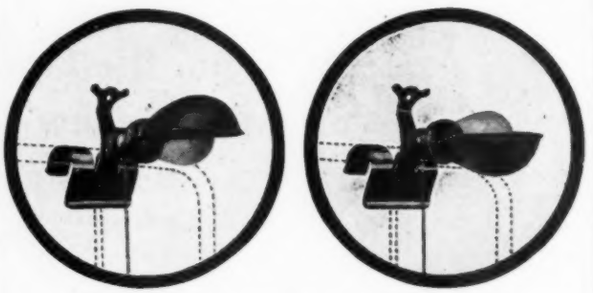
SHELLKOTE ON HOSPITAL WALLS gives an absolutely sanitary, washable, and durable surface. You do not have to recoat after using Shellkote, but simply wash and you have a permanent finish that will never crack or peel. One gallon of Shellkote covers 800 square feet. Write us for further information. The Purcell Paint Manufacturing Company, Elyria, Ohio.

Continued on page 54.

BED LIGHTING

FOR

HOSPITALS



The HANDY LIGHT is designed to meet your requirements. The need for a scientifically correct bed light brought about its invention.

THE HANDY LIGHT can be easily cleaned and kept sanitary.

THE HANDY LIGHT is equipped with pull chain of desired length, which is easily reached by patient or nurse to turn on or off.

THE HANDY LIGHT is one flexible unit, with no parts to come loose or screws to adjust. Reflector retains various positions by gravity.

THE HANDY LIGHT is used for direct or indirect lighting. The swiveled revolving reflector gives any volume of light—from soft night light to reading light of desired intensity.

THE HANDY LIGHT is adaptable for bedside diagnostic purposes.

THE HANDY LIGHT because of its correctly designed and finished reflector, is economical to use. A 16- or 32-candle power Carbon or a 10- to 60-watt Mazda or Tungsten lamp of any desired voltage will operate in it.

THE HANDY LIGHT is manufactured only of material passed by the National Board of Fire Underwriters. The lamp cord has several times the required capacity for carrying electricity—hence absolute safety and durability.

THE HANDY LIGHT weighs less than a pound, is easily lifted on or off of bed, will throw light where wanted, and in every way suits every use to which a hospital bed light should be put.

THE HANDY LIGHT is pleasing in appearance, finished in brushed brass, heavily lacquered, and equipped with ten feet silk cord and swivel plug ready to attach to any socket.

The only genuine HANDY LIGHT is made in Cincinnati by The Handy Light Co.

We want to standardize the bed lighting of your hospital with HANDY LIGHTS, and offer a quantity price for an entire installation or for such quantity as you are prepared to use at present. So you may see the Handy Light and test it out without expense to you, we make the following

SAMPLE OFFER

Any hospital superintendent or head nurse may obtain a Handy Light for trial use in the hospital by simply sending name on a hospital letter head. A HANDY LIGHT will be shipped prepaid and billed on memorandum. It may be returned at our expense and bill ignored. Send for sample today while you have it in mind.

THE HANDY LIGHT CO.

2193 Handy Light Block
CINCINNATI, OHIO

CLASSIFIED ADVERTISING.

Continued from page 52.

MISCELLANEOUS—Continued.

CREAM OF RYE FOR BREAKFAST—Literature, clinical reports, and full-sized package mailed on request to any hospital or charitable institution. Refer to our announcements on page 46 of this issue. Minneapolis Cereal Company, Minneapolis, Minn.

STANDARD NURSES' UNIFORMS—An illustration of our striped seersucker nurses' uniform is shown in our announcement on page 84 of this issue. We sell direct to the hospital or the individual nurse. Write for catalog showing styles and prices. Randles Manufacturing Company, Ogdensburg, N. Y.

HAVE YOU YOUR COPY OF OUR THERAPEUTIC PRICE LIST (1913-1914)?—This book is more than its name implies, a mere price list. It contains over 400 pages, 5x8, and one department alone has 100 pages of clinical suggestions. Every hospital superintendent and doctor should have a copy. It is yours for the asking. The Abbott Alkaloidal Company, Chicago.

HOSPITAL AND INSTITUTION CATALOG—Free, by prepaid express. It embraces every article demanded in the kitchen, dining room, ward, dormitory, bathroom, etc., of a hospital. Address Albert Pick & Co., Chicago.

HOSPITAL CATALOGUE OF HYDROTHERAPEUTIC APPARATUS—Our exhaustive catalogue will be sent free if you are interested in hydrotherapy. James B. Clow & Sons, Chicago.

ABSORBENT COTTON—Absorbent Cotton of quality at lowest prices. Samples and prices on request. Maplewood Mills, largest manufacturers in the world, Fall River, Mass.

FLOOR DRESSING—The Richardson Floor Dressing can be used on new and old floors of wood, cement, brick, and linoleum. It is economical, odorless, and can be washed with soap and water or antiseptics. Manufactured by Charles F. Richardson, 46 Cornhill, Boston, consultant in architectural treatment and finish of wood.

HEALTH FOOD—The Uncle Sam Health Food combines healing laxative flaxseed with specially prepared macaroni wheat, and the ingredients form an ideal laxative food that has a nut-like and captivating taste. Write us for a free trial package. Uncle Sam Breakfast Food Company, Omaha, Neb.

PURE COFFEE—The quality and preparation of Yale Coffee are such that we can confidently recommend for use in your institution. Prove our recommendation by a trial. Steinwender-Stoffregen Coffee Company, St. Louis, Mo.

NURSES' UNIFORMS—Several of our special lines of nurses' uniforms are listed and prices quoted in our announcement on page 67 of this number. Fuller particulars given in our folder, which will be sent on request. S. E. Badanes Company, 151-153 West 19th street, New York City.

HOSPITAL RECORD SYSTEM—The problem of keeping your hospital records can be solved by our expert service. We will recommend improvements in your present system or devise a new one for you. Send for sample stock forms and quotations. Physicians' Record Company, 307 North Fifth avenue, Chicago.

SAMPLES OF HOSPITAL PAINT—Keystone flat finish, the original paint for hospitals, is sanitary, antiseptic, fire-retarding, and washable. Blood, pencil marks, or dirt of any kind can be cleaned from the Keystona surface. Address Keystone Varnish Company, Brooklyn, N. Y.

KEEP YOUR PLUMBING OPEN—This can be done and plumbers' bills can be saved by using my specialties described on page 43 of this journal. Allan J. Coleman, 168 N. Michigan avenue, Chicago.

HEALTH FOOD—A cereal food combining the laxative qualities of flax-seed with specially prepared macaroni wheat and other ingredients by a specially patented process is supplied in Uncle Sam Breakfast Food, the ideal food for hospital patients, nurses, and physicians. Write for fuller particulars to Uncle Sam Breakfast Food Company, Omaha, Neb.

CALOX TOOTH POWDER—This oxygen dentifrice is something more than a mechanical cleansing agent; its use as a tooth powder is not only a luxury, but a notable advance in mouth hygiene. Nurses and hospital physicians will be supplied with free samples if mention is made of this journal. McKesson & Robbins, New York.

NEW X-RAY MANUAL FREE—Written by an expert röntgenologist. Will be sent on request to any one mentioning this journal. The novice will find this manual full of practical suggestions, and the expert will be reminded of many things he has forgotten. Address G., Cramer Dry Plate Company, St. Louis.

INVALID LIFTER—Our device used in your hospital will add to the comfort of your patients and will assist the nurse in the performance of her duties. Tested to hold 300 pounds. See illustration on page 10, and send for descriptive literature. F. S. Root Company, 14 Wareham Street, Springfield, Mass.

AIR MOISTENER—Our device is simple and effective, and will maintain the humidity that is necessary in the air breathed by your patients. Write us and we will furnish full information and prices. Savo Manufacturing Company, 5856 South Park Avenue, Chicago, Ill.

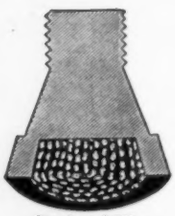
ICE BREAKER—Our Creasy Ice Breaker can be quickly changed to break the ice in five different grades. It is a time and labor saving device you should have. Ask for Ice Users' Handbook. Jos. S. Lovering Wharton, 3112 North 17th Street, Philadelphia, Pa.

PHARMACEUTICAL PRODUCTS—Distinctively individual are the pharmaceutical products which bear our trade-mark. Each preparation represents distinctive qualities which physicians prescribing them have been quick to observe. We want you to become acquainted with the therapeutic application of our preparations, and on request will mail interesting circular matter. Address Knoll & Co., 45 John street, New York City.

DIRECTORY OF SANATORIUMS—INSTITUTIONS FOR NERVOUS AND MENTAL DISEASES

FOSTER CANE AND CRUTCH TIPS AND TIPS FOR CHAIRS AND TABLES

SOCKET TIPS.
Friction plug or plain —6 sizes.



Sectional View.

SOLID SCREW TIPS.
Friction plug or plain—3 sizes.

Sectional View.

WHITTEMORE TIPS.
Friction plug or plain—3 sizes.

SECURE SAFETY AND SILENCE IN THE HOSPITAL

Quiet and silence are prerequisites in the care of the sick, and nervous patients are easily irritated by the "clicking" of unshod crutches and the noisy movement of chairs and tables. These noises not only irritate, but have a tendency to hinder the recovery of a patient. The Foster Cane and Crutch Tips not only prevent noise and aid the user, but also prevent slipping.

RUBBER STEM TIPS.
Friction plug in center—2 sizes.

Sectional View.

PUNCH PROTECTION.
Specially prepared fabric at the sides of the tip prevents the crutch from punching through the bottom.

CORRUGATED BOTTOM.
The bottom of the tip is so corrugated that it adheres firmly to the smooth floor or sidewalk and prevents slipping.

CONCAVE STEEL WASHER.
The washer is so arranged that the tip will wear level on the bottom, thus doubling the wearing quality.

SAVE EXPENSE IN THE HOSPITAL

One of the great expenses of the hospital is repainting the walls where they have been scratched by the backs of chairs, dressers, and chiffoniers coming in contact with them, and at the same time marring and injuring the articles of furniture.

SCOTT LEATHER CUSHION CHAIR TIPS.
Wearing surface cushioned with felt.

CHAIR TIP ADJUSTER.
Set for adjusting the Scott patent special Chair Tips.

ROCKING CHAIR TIPS.
Makes rocking comfortable and noiseless.

ALL TIPS ARE MADE OF SPECIAL MATERIAL

Foster Friction Plug Cane and Crutch Tips are so made that they will wear longer than any other tip and cannot come off. The Chair Tips fully protect both the walls and furniture, and are easily adjusted.

WRITE TODAY FOR COMPLETE PRICE LIST

FOSTER RUBBER COMPANY

Originators and Patentees of the Foster Friction Plug, Which Prevents Slipping

105 Federal Street, BOSTON, MASS.

DIRECTORY OF HOSPITAL SUPPLIES

Continued on page 55.

DIRECTORY OF HOSPITAL SUPPLIES

Continued from page 71.

Continued on page 86.

DIRECTORY OF HOSPITAL SUPPLIES

Continued from page 85.

Eye Comfort

THE importance of proper lighting for hospitals cannot be overstated. Dr. A. J. Ochsner, the famous Chicago surgeon, says:

"If there is any time at which a person's eyes are more likely to be injured than at any other, it is when the general condition of the patient is below the normal, which is usually the case with patients confined to hospitals."

The EYE COMFORT System of Indirect Lighting (with X-Ray Reflectors) is being generally adopted for use in hospitals where the *necessity of correct lighting* is recognized.

No hospital can be properly equipped without EYE COMFORT Lights. They relieve eye-strain, abolish glare, produce a soft, even, restful illumination, and are in every respect the best lights for wards, private rooms, nurses' quarters, and operating rooms.

We construct fixtures and arrange lighting units to conform to architectural requirements.

Write for our book, "The Logical Light for the Hospital." It contains a fund of information on hospital lighting, in addition to valuable articles by physicians, architects, and lighting experts. A copy will be mailed to you free on request.

National X-Ray Reflector Company

249 West Jackson Boulevard CHICAGO

New York Office, Craftsman Building
10 East 39th Street

Post-Hospital Treatment For Women Who Need Conditioning

Even after the most successful hospital treatment, many women require systematic physical training if permanent benefits are to be secured.

Remedial exercises for near-neurasthenics must be of a character that will arouse sufficient mental interest and incentive to dispel the languor and indifference usual to this class of patients. It is easy to tell these patients to take plenty of exercise and be careful in their diet, but it is difficult to induce them to follow this simple prescription.

Permanent results can be attained only when the patient is taught how to stand correctly, how to breathe and how to exercise normally. Every hospital practitioner has cases which would be greatly benefited by a scientific, individualized, personally-directed course of proper exercise, breathing, bathing and diet. My exercise will materially help your cases of chronic Constipation, Indigestion, Anemia, Neurasthenia, Weakened Heart Muscles, Undeveloped Lungs, Poor Circulation, and will increase the resistance, by building up and strengthening the physical and nervous system.

PHYSICIANS APPROVE OF MY WORK when they know its character; those who fully understand it frankly welcome my help for certain classes of their patients. The mental interest and incentive developed by the individual lessons dispel that indifference which physicians often find hard to overcome in some patients.

It is my custom to study each pupil's special requirements, and prescribe for her individually. I give no promiscuous exercise, but direct each woman according to her needs and her strength. I have spent years in the study of anatomy and physiology, and accept no cases where pronounced pathological conditions are present, as I know the possibilities of my work and I realize its limitations.

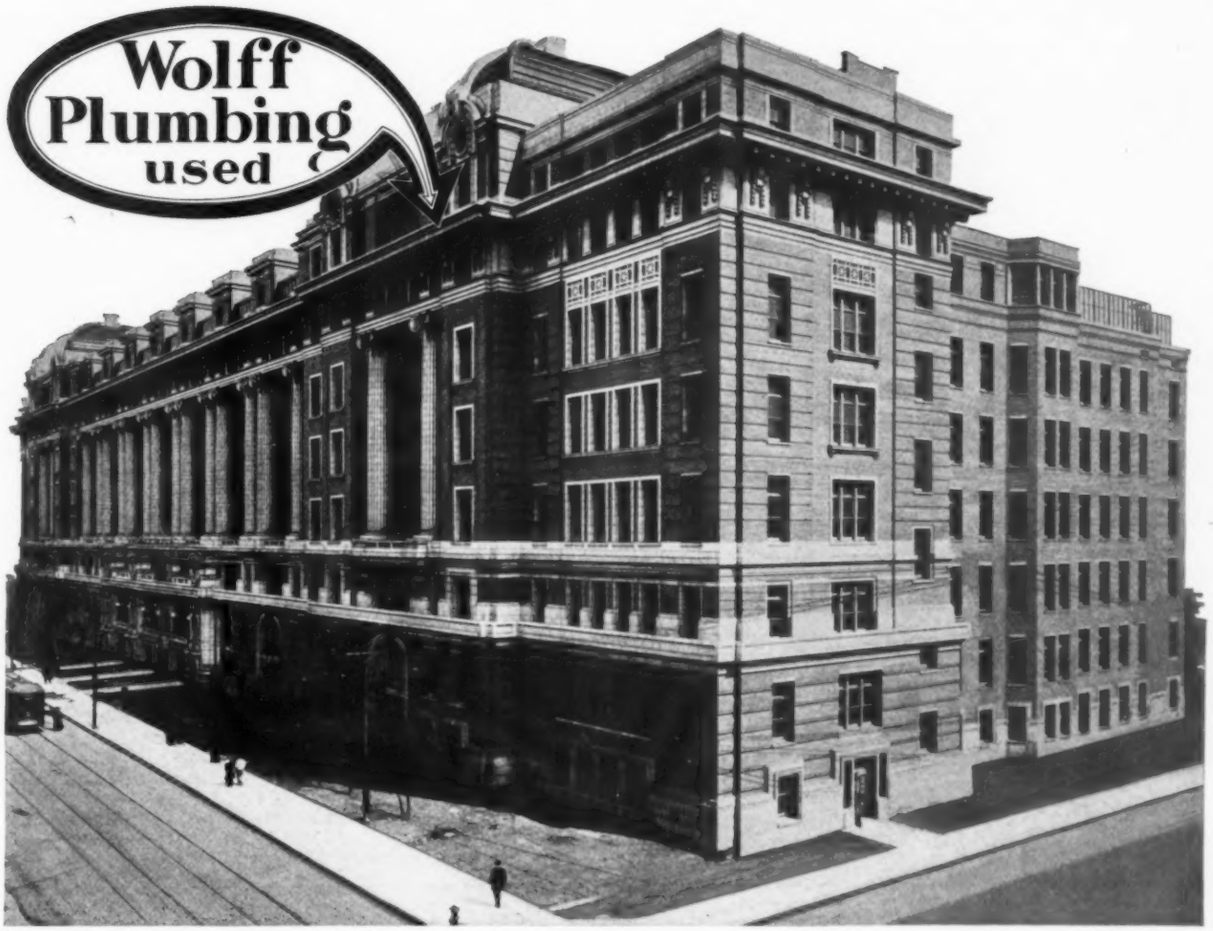
In many cases I insist that the pupil have the consent and advice of her physician; in others, a regular weekly examination by physicians is required.

For 12 years I gave personal instruction to women before attempting instruction by mail.

SUSANNA COCROFT

Dept. 104 — 624 Michigan Avenue, CHICAGO

Miss Cocroft has perhaps had a wider experience than any woman in America in prescribing remedial exercises for women.



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County Architect, Chicago

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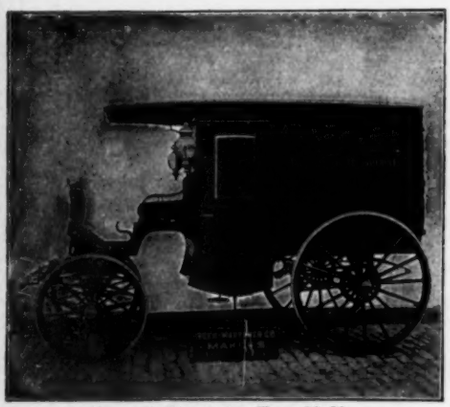

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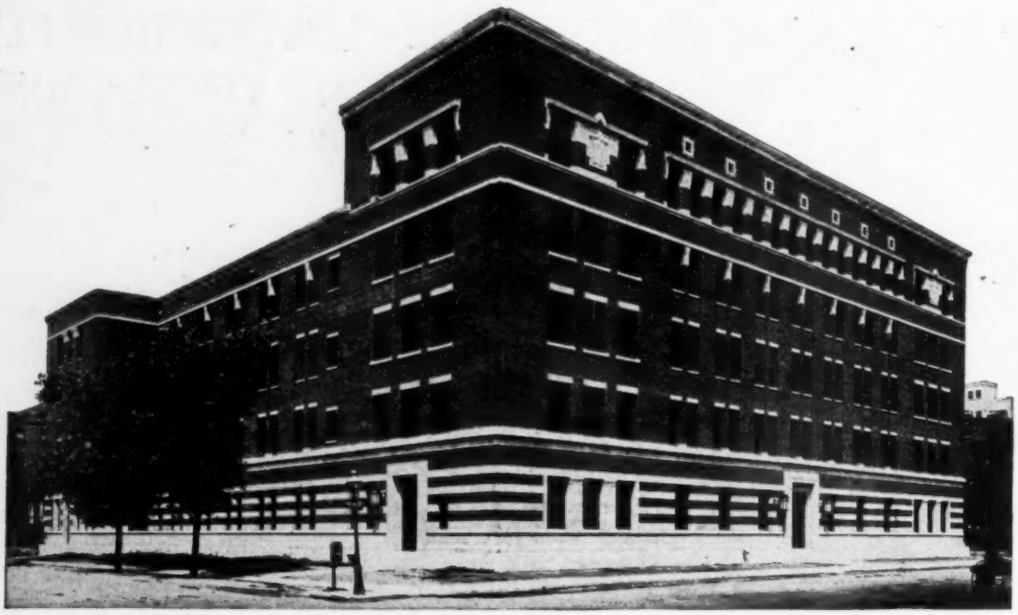

Cook County Detention Hospital, Chicago, Ill.
Richard A. Schmidt, Architect

"OH! Any material is good enough for a laundry chute. I specify glazed tile, usually," was the reply an architect made before a hospital building board recently to a question asked by the superintendent.

He did not secure the contract, for his remark created a prejudice as a result of the ignorance displayed on a detail which is rapidly becoming recognized as being fully as important as the plumbing.

No hospital should contain a chute which cannot be easily maintained in a state of absolute cleanliness.

There is one chute which can be so maintained. It is the **Pfaudler Chute, of Glass Enameled Steel.**

Just picture to yourself a chute 24 inches in diameter, made of steel rings, the inner walls of which are lined with a glass enamel. The light gray of the steel shows through the translucent enamel, giving the interior walls a very light gray color. The chute is equipped with plate glass doors at each floor, and it is open at the roof, usually protected by a skylight hood, which still permits the sunshine to flood it with its beneficent rays. A flushing ring at its head also permits of flooding its walls with hot water at will.

The first chute installed was specified two and one-half years ago by Schmidt, Garden & Martin, of Chicago. These architects have since specified it for five other hospitals, one of which is pictured above.

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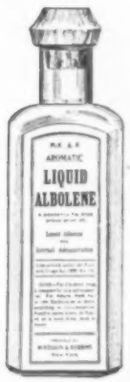

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